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Arizona Administrative REGISTER

Published by the Department of State ~ Office of the Secretary of State

Volume 29, Issue 47 **~ Administrative Register Contents ~** **November 24, 2023**

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From the Publisher

ABOUT THIS PUBLICATION

The authenticated pdf of the *Administrative Register* (A.A.R.) posted on the Arizona Secretary of State's website is the official published version for rulemaking activity in the state of Arizona.

Rulemaking is defined in Arizona Revised Statutes known as the Arizona Administrative Procedure Act (APA), A.R.S. Title 41, Chapter 6, Articles 1 through 10.

The *Register* is cited by volume and page number. Volumes are published by calendar year with issues published weekly. Page numbering continues in each weekly issue.

In addition, the *Register* contains notices of rules terminated by the agency and rules that have expired.

ABOUT RULES

Rules can be: made (all new text); amended (rules on file, changing text); repealed (removing text); or renumbered (moving rules to a different Section number). Rulemaking activity published in the *Register* includes: proposed, final, emergency, expedited, and exempt rules as defined in the APA, and other state statutes.

New rules in this publication (whether proposed or made) are denoted with underlining; repealed text is stricken.

WHERE IS A "CLEAN" COPY OF THE FINAL OR EXEMPT RULE PUBLISHED IN THE *REGISTER*?

The *Arizona Administrative Code* (A.A.C) contains the codified text of rules. The A.A.C. contains rules promulgated and filed by state agencies that have been approved by the Attorney General or the Governor's Regulatory Review Council. The *Code* also contains rules exempt from the rulemaking process.

The authenticated pdf of *Code* Chapters posted on the Arizona Secretary of State's website are the official published version of rules in the A.A.C. The *Code* is posted online for free.

LEGAL CITATIONS AND FILING NUMBERS

On the cover: Each agency is assigned a Chapter in the *Arizona Administrative Code* under a specific Title. Titles represent broad subject areas. The Title number is listed first; with the acronym A.A.C., which stands for the *Arizona Administrative Code*; following the Chapter number and Agency name, then program name. For example, the Secretary of State has rules on rulemaking in Title 1, Chapter 1 of the *Arizona Administrative Code*. The citation for this Chapter is 1 A.A.C. 1, Secretary of State, Rules and Rulemaking.very document filed in the office is assigned a file number. This number, enclosed in brackets, is located at the top right of the published documents in the *Register*. The original filed document is available for 10 cents a page.

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ADMINISTRATIVE REGISTER
This publication is available online for free at www.azsos.gov.

ADMINISTRATIVE CODE
The *Arizona Administrative Code* is available online at www.azsos.gov.

PUBLICATION DEADLINES
Publication dates are published in the back of the *Register.* These dates include file submittal dates with a three-week turnaround from filing to published document.

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The Office of the Secretary of State is an equal opportunity employer.

Participate in the Process

Look for the Agency Notice

Review (inspect) notices published in the *Arizona Administrative Register.* Many agencies maintain stakeholder lists and would be glad to inform you when they proposed changes to rules. Check an agency's website and its newsletters for news about notices and meetings.

Feel like a change should be made to a rule and an agency has not proposed changes? You can petition an agency to make, amend, or repeal a rule. The agency must respond to the petition. (See A.R.S. § 41-1033)

Attend a public hearing/meeting

Attend a public meeting that is being conducted by the agency on a Notice of Proposed Rulemaking. Public meetings may be listed in the Preamble of a Notice of Proposed Rulemaking or they may be published separately in the *Register*. Be prepared to speak, attend the meeting, and make an oral comment.

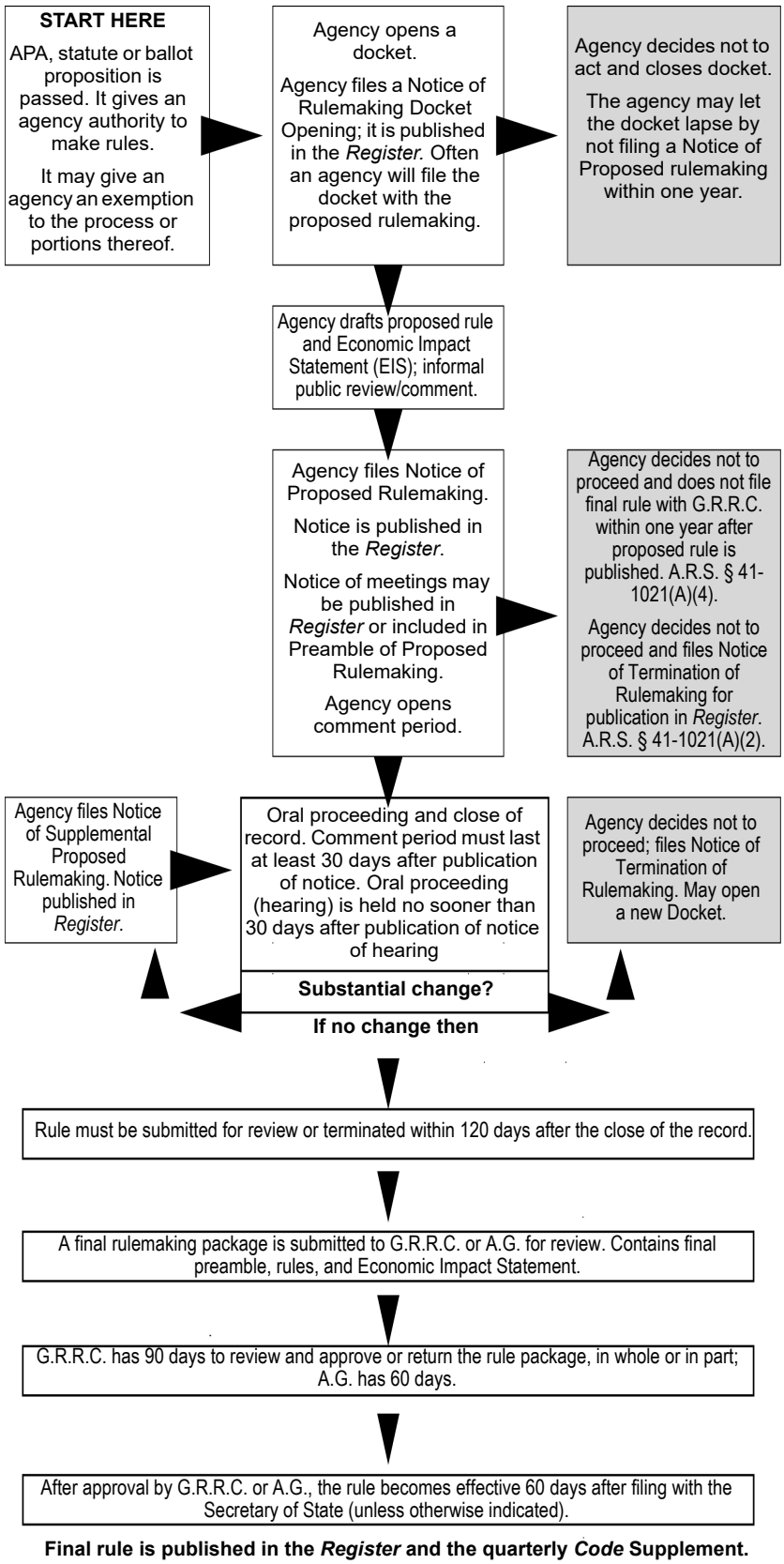
An agency may not have a public meeting scheduled on the Notice of Proposed Rulemaking. If not, you may request that the agency schedule a proceeding. This request must be put in writing within 30 days after the published Notice of Proposed Rulemaking.

Write the agency

Put your comments in writing to the agency. In order for the agency to consider your comments, the agency must receive them by the close of record. The comment must be received within the 30-day comment timeframe following the *Register* publication of the Notice of Proposed Rulemaking.

You can also submit to the Governor's Regulatory Review Council written comments that are relevant to the Council's power to review a given rule (A.R.S. § 41-1052). The Council reviews the rule at the end of the rulemaking process and before the rules are filed with the Secretary of State.

Arizona Regular Rulemaking Process



Final rule is published in the *Register* and the quarterly *Code* Supplement.

Definitions

***Arizona Administrative Code* (A.A.C.):** Official rules codified and published by the Secretary of State's Office. Available online at www.azsos.gov.

***Arizona Administrative Register* (A.A.R.):** The official publication that includes filed documents pertaining to Arizona rulemaking. Available online at www.azsos.gov.

Administrative Procedure Act (APA): A.R.S. Title 41, Chapter 6, Articles 1 through 10. Available online at www.azleg.gov.

Arizona Revised Statutes (A.R.S.): The statutes are made by the Arizona State Legislature during a legislative session. They are complied by Legislative Council, with the official publication codified by Thomson West. Citations to statutes include Titles which represent broad subject areas. The Title number is followed by the Section number. For example, A.R.S. § 41-1001 is the definitions Section of Title 41 of the Arizona Administrative Procedures Act. The "§" symbol simply means "section." Available online at www.azleg.gov.

Chapter: A division in the codification of the *Code* designating a state agency or, for a large agency, a major program.

Close of Record: The close of the public record for a proposed rulemaking is the date an agency chooses as the last date it will accept public comments, either written or oral.

Code of Federal Regulations (CFR): The *Code of Federal Regulations* is a codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government.

Docket: A public file for each rulemaking containing materials related to the proceedings of that rulemaking. The docket file is established and maintained by an agency from the time it begins to consider making a rule until the rulemaking is finished. The agency provides public notice of the docket by filing a Notice of Rulemaking Docket Opening with the Office for publication in the *Register*.

Economic, Small Business, and Consumer Impact Statement (EIS): The EIS identifies the impact of the rule on private and public employment, on small businesses, and on consumers. It includes an analysis of the probable costs and benefits of the rule. An agency includes a brief summary of the EIS in its preamble. The EIS is not published in the *Register* but is available from the agency promulgating the rule. The EIS is also filed with the rulemaking package.

Governor's Regulatory Review (G.R.R.C.): Reviews and approves rules to ensure that they are necessary and to avoid unnecessary duplication and adverse impact on the public. G.R.R.C. also assesses whether the rules are clear, concise, understandable, legal, consistent with legislative intent, and whether the benefits of a rule outweigh the cost.

Incorporated by Reference: An agency may incorporate by reference standards or other publications. These standards are available from the state agency with references on where to order the standard or review it online.

Federal Register (FR): The *Federal Register* is a legal newspaper published every business day by the National Archives and Records Administration (NARA). It contains federal agency regulations; proposed rules and notices; and executive orders, proclamations, and other presidential documents.

Session Laws or "Laws": When an agency references a law that has not yet been codified into the Arizona Revised Statutes, use the word "Laws" is followed by the year the law was passed by the Legislature, followed by the Chapter number using the abbreviation "Ch.", and the specific Section number using the Section symbol (§). For example, Laws 1995, Ch. 6, § 2. Session laws are available at www.azleg.gov.

United States Code (U.S.C.): The Code is a consolidation and codification by subject matter of the general and permanent laws of the United States. The Code does not include regulations issued by executive branch agencies, decisions of the federal courts, treaties, or laws enacted by state or local governments.

Acronyms

A.A.C. – *Arizona Administrative Code*

A.A.R. – *Arizona Administrative Register*

APA – Administrative Procedure Act

A.R.S. – Arizona Revised Statutes

CFR – *Code of Federal Regulations*

EIS – Economic, Small Business, and Consumer Impact Statement

FR – *Federal Register*

G.R.R.C. – Governor's Regulatory Review Council

U.S.C. – *United States Code*

About Preambles

The Preamble is the part of a rulemaking package that contains information about the rulemaking and provides agency justification and regulatory intent.

It includes reference to the specific statutes authorizing the agency to make the rule, an explanation of the rule, reasons for proposing the rule, and the preliminary Economic Impact Statement.

The information in the Preamble differs between rulemaking notices used and the stage of the rulemaking.

NOTICES OF FINAL RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Final Rulemaking. Final rules have been through the regular rulemaking process as defined in the Administrative Procedures Act. These rules were either approved by the Governor's Regulatory Review Council or the Attorney General's Office. Certificates of Approval are on file with the Office.

The final published notice includes a preamble and text of the rules as filed by the agency.

Economic Impact Statements are not published but are filed by the agency with their final notice.

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the final rules should be addressed to the agency that promulgated them. Refer to item #5 to contact the person charged with the rulemaking.

The codified version of these rules will be published in the *Arizona Administrative Code*.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS INSURANCE DIVISION

[R23-229]

PREAMBLE

1. Article, Part, or Section Affected (as applicable) — **Rulemaking Action**

R20-6-401	Amend
R20-6-405	Amend
R20-6-409	Amend

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 20-143(A)

Implementing statute: R20-6-401: A.R.S. § 20-143(B); R20-6-405: A.R.S. § 20-1078; R20-6-409: A.R.S. § 20-821(A)

3. The effective date of the rule:

January 7, 2024

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 1203, May 26, 2023

Notice of Proposed Rulemaking: 29 A.A.R. 1167, May 26, 2023

5. The agency's contact person who can answer questions about the rulemaking:

Name:	Mary E. Kosinski
Address:	Department of Insurance and Financial Institutions 100 N. 15th Ave., Suite 261 Phoenix, AZ 85007-2630
Telephone:	(602) 364-3476
Email:	mary.kosinski@difi.az.gov
Website:	https://difi.az.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Arizona Department of Insurance and Financial Institutions – Insurance Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 6, Sections R20-6-401, R20-6-405 and R20-6-409. (The Department has already completed a rulemaking for the only other Section in Article 4, R20-6-407. Service Companies, which became effective on February 6, 2023 (28 A.A.R. 3968, December 30, 2022)).

The Department's changes are necessary to fulfill commitments made in prior Five-Year Review Reports, the most recent is the Department's 2020 Five-Year Report for these Sections. The Department is proposing the following changes:

- Section R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers. Correct page numbers in the incorporated by reference material, and update the physical address of the Department.
- Section R20-6-405. Health Care Service Organizations. Eliminate unnecessary subsections and renumber remaining subsections, modernize antiquated language for readability, eliminate redundant statutory definitions and subsections, eliminate references to obsolete forms, eliminate unnecessary requirements, eliminate filing of reports related to advertising matter and sales materials, and clarify that appointments are not filed with the Department.
- Section R20-6-409. Hospital, Medical, Dental, and Optometric Service Corporations. Update the Sections to which subscription contracts must comply and eliminate an unnecessary subsection.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review and does not propose to rely on any study relevant to this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

The rulemaking does not diminish a previous grant of authority granted to the Department.

9. The summary of the economic, small business, and consumer impact:

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to address any misconduct. Instead, it is necessary to fulfill commitments made by the Department in previous Five-Year Review Reports, the most recent in 2020. The proposed changes, including the elimination of a requirement to report information the Department receives pursuant to other statutory mandates, should make compliance with these Sections easier for regulated entities.
- Because this rulemaking is not made in response to a perceived problem caused by the conduct of licensees, it is not intended to reduce the frequency of any potentially violative conduct.

Pursuant to A.R.S. § 41-1055(A)(2):

- The Department does not anticipate any additional costs to be incurred by licensees.
- The person listed in Item 5 may be contacted to submit or request additional data on the information included in the economic, small business and consumer impact statement.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department has made the following changes from the proposed rulemaking:

- The Department added a link to its website to Section R20-6-401 as a source for the incorporated materials.
- The Department removed the "incorporated by reference" language found at subsection R20-6-405(K).

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department published the Notice of Proposed Rulemaking for Sections R20-6-401, R20-6-405 and R20-6-409 on May 26, 2023. (29 A.A.R. 1167, May 26, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters prescribed by statute are applicable to the Department or to any specific rule or class of rules.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable. Sections R20-6-401 and R20-6-409 do not require a permit.

Section R20-6-405 pertains to a Health Care Service Organization ("HCSO"). A.R.S. § 20-1052 requires a HCSO to obtain a certificate of authority from the Department before engaging in the business of a HCSO, not a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

No federal law is applicable to the subject of the rules. However, the deposit requirement for a Health Care Services Organization may be subject to a federal preemption claim pursuant to subsection R20-6-405(H)(2).

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

Section R20-6-401 incorporates the National Association of Insurance Commissioners Model Laws, Regulations and Guidelines, Volume III, pp. 490-1 through 490-33, Regulation Regarding Proxies, Consents, and Authorization of Domestic Stock Insurers, April 1995 (and no future editions or amendments).

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable. None of the Sections being amended in this rulemaking were previously made, amended or repealed as an emergency rule.

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS INSURANCE DIVISION

ARTICLE 4. TYPES OF INSURANCE COMPANIES

Section
R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers
R20-6-405. Health Care Services Organization
R20-6-409. Hospital, Medical, Dental, and Optometric Service Corporations

ARTICLE 4. TYPES OF INSURANCE COMPANIES

R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers

A. The Department incorporates by reference National Association of Insurance Commissioners Model Laws, Regulations and Guidelines, Volume III, pp. 490-1 through ~~490-40,~~ 490-33, Regulation Regarding Proxies, Consents, and Authorization of Domestic Stock Insurers, April 1995 (and no future editions or amendments), which is on file with and available from the Department of Insurance, 100 N. 15th Ave., Suite ~~102,~~ 261, Phoenix, AZ ~~85007-2624~~ 85007-2630, the Department's website: https://difi.az.gov/insurance-division-rulemaking, and the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197, modified as follows:

Section 1 A is modified to read: "No domestic stock insurer that has any class of equity securities held of record by 100 or more persons, or any director, officer or employee of that insurer, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent, or authorization in respect to any class of equity securities in contravention of this regulation and Schedules A and B, hereby made a part of this regulation.

B. Domestic stock insurance companies shall comply with this Section as required under A.R.S. § 20-143(B).

R20-6-405. Health Care Services Organization

A. ~~Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-106 and 20-1051 through 20-1068.~~

~~B.~~ ~~Purpose. The purpose of this rule is to implement the legislative intent, as expressed in Chapter 128, Laws of 1973, to regulate and control Health Care Services Organizations in the State of Arizona, (including, but not limited to Certificate of Authority, licensing, fees for licensing, disciplinary procedures for agents and control of solicitation of members and evidences of coverage).~~

~~C.~~ Scope

1. The scope of this ~~Rule~~ Section is the scope of A.R.S. Title 20 as it relates to Insurers or Hospital or Medical Service Corporations. As it relates to Health Care Services Organizations, the scope of this ~~rule~~ Section is the scope of Title 20, Chapter 1 and Title 20, Chapter 4, Article 9, as provided in A.R.S. § 20-1068. This ~~rule~~ Section is applicable to agents of persons, and persons operating or proposing to operate Health Care Services Organizations in the State of Arizona.
2. The statutory authority for this ~~rule,~~ Section, A.R.S. Title 20, Chapter 4, Article 9, does not provide for exemptions ~~therefrom~~ for persons or agents of persons subject ~~thereto,~~ to A.R.S. Title 20, Chapter 4, Article 9, and no such exemption is intended or should be presumed by this ~~rule~~ Section or any provision ~~thereof.~~ of this Section.

~~D.~~B. Repeal. This ~~rule~~ Section does not repeal any known prior ~~rule,~~ Section, memorandum, bulletin, directive or opinion on this subject matter. If such prior ~~rule~~ Section or directive exists and is in conflict ~~herewith, the same is repealed hereby.~~ with this Section, it is repealed by this Section.

~~E.~~C. Definitions. ~~As used in this rule, unless the context otherwise requires:~~ In addition to the definitions provided in A.R.S. § 20-1051, the following definitions apply to this Section unless the context otherwise requires:

1. "Agent" has the same meaning as "insurance producer" ~~of A.R.S. § 20-282.~~ found at A.R.S. § 20-281(5).
2. ~~"Basic Health Care Services" has the meaning of A.R.S. § 20-1051.~~ "Certificate of Authority" has the meaning found at A.R.S. § 20-217.
3. ~~"Certificate of Authority" means a Certificate authorizing operation of a Health Care Services Organization.~~ "Director" has the meaning found at A.R.S. § 20-102.
4. ~~"Director" means the Director of Insurance of the State of Arizona.~~ "Hospital Service Corporation" has the meaning found at A.R.S. § 20-822.
5. ~~"Enrollee" has the meaning of A.R.S. § 20-1051.~~ "Insurer' has the meaning found at A.R.S. § 20-104.
6. ~~"Evidence of coverage" has the meaning of A.R.S. § 20-1051.~~ "License" means the authority to act as an agent of a Health Care Services Organization.
7. ~~"Health Care Plan" has the meaning of A.R.S. § 20-1051.~~ "Medical Service Corporation" has the meaning found at A.R.S. § 20-822.
8. ~~"Health Care Services" has the meaning of A.R.S. § 20-1051.~~ "Net charges" means the total of all sums prepaid by or for all enrollees, less approved refunds, adjustments and deductions, as consideration for Health Care Services of a Health Care Plan under an Evidence of Coverage.

9. ~~"Health Care Services Organizations" has the meaning of A.R.S. § 20-1051.~~ "Physician and patient relationship" has the meaning found at A.R.S. § 20-833.
10. ~~"Hospital Service Corporation" has the meaning of A.R.S. § 20-822.~~ "Prepaid Group Practice Plan" means a person authorized and approved under A.R.S. Title 20.
11. ~~"Insurer" has the meaning of A.R.S. § 20-106(C).~~ "Prepaid Health Plan" means any Health Care Plan to pay or make reimbursement for Health Care Services on a prepaid basis other than insured plans otherwise authorized and approved under A.R.S. Title 20.
12. ~~"License" means the authority to act as an agent of a Health Care Services Organization.~~ "Transact" has the meaning found at A.R.S. § 20-106(A) and (B).
13. ~~"Medical Service Corporation" has the meaning of A.R.S. § 20-822.~~ "Unqualified agent" means a person directly or indirectly representing or acting for a Health Care Services Organization and not qualified as an agent thereof.

~~14. "Net charges" means the total of all sums prepaid by or for all enrollees, less approved refunds, adjustments and deductions, as consideration for Health Care Services of a Health Care Plan under an Evidence of Coverage.~~
~~15. "Person" has the meaning of A.R.S. § 20-1051.~~
~~16. "Physician and patient relationship" has the meaning of A.R.S. § 20-833.~~
~~17. "Prepaid Health Plans" means any Health Care Plan to pay or make reimbursement for Health Care Services on a prepaid basis other than insured plans otherwise authorized and approved under A.R.S. Title 20.~~
~~18. "Prepaid Group Practice Plan" means a person authorized and approved under A.R.S. Title 20.~~
~~19. "Provider" has the meaning of A.R.S. § 20-1051.~~
~~20. "Transact" has the meaning of A.R.S. § 20-106(A) and (B).~~
~~21. "Unqualified agent" means a person directly or indirectly representing or acting for a Health Care Services Organization and not qualified as an agent thereof.~~

~~F.~~**D.** ~~Certificate of Authority~~

~~1. Policy. Persons and agents of persons operating Health Care Services Organizations as of May 7, 1973, shall comply with the application requirements of A.R.S. § 20-1052 on or before August 7, 1973.~~
~~2. A Certificate of Authority shall not be granted until the Director is satisfied that the requirements of A.R.S. §§ 20-1052, 20-1053 and 20-1054 are met and will continue to be met.~~
~~3. An examination of an applicant at the expense of the applicant for a Certificate of Authority may be ordered to be made if the applicant is not a resident, is controlled by a non-resident, or maintains a head or principal office out of its service area, and will be ordered to be made if the applicant contracts with providers, or for services outside a reasonable area, or has contract obligations under its evidence of coverage that are, or appear to be, inequitable or unreasonable as to the enrollees.~~

~~G.~~ Certificate of Authority – Application

1. ~~A person required to be qualified to do business in this State as a Health Care Services Organization, pursuant to A.R.S. § 20-1052 shall file an application for Certificate of Authority on Department Form E-104.~~
   Pursuant to the authority of A.R.S. § 20-1053(A)(13), the Director finds that biographical information disclosing the past activities, employment and financial transactions of principals, principal officers, controlling persons, and agents of applicant Health Care Services Organizations is necessary for the protection of residents of this State.
2. ~~Applications failing to comply with the requirements of A.R.S. § 20-1053 will be denied without prejudice to the filing of an application complying with such requirements.~~
   Pursuant to the authority of A.R.S. § 20-1053(A)(13), the Director finds that records of fingerprints of principal officers and agents of applicant Health Care Services Organizations may be necessary for the protection of citizens of this state and may be required prior to licensing or approval of a Certificate of Authority.
3. ~~Health Care Services Organizations operating in this State as of May 7, 1973, and having submitted a sufficient application for Certificate of Authority as required by this rule, including the disclosure filings of paragraph (7) of this subsection, may continue to operate as an organization until the Director acts upon the application.~~
4. ~~The application for Certificate of Authority shall be verified by an authorized and qualified officer of the Health Care Services Organization.~~
5. ~~The application for Certificate of Authority shall be accompanied by the fees required for a hospital or medical service corporation by A.R.S. § 20-167 and a tax return or returns on Department Form E-162, for the calendar year previous to the calendar year of application during which the applicant has done business in this State as a Health Care Services Organization, and the amount of tax due thereon after the effective date hereof, if any, as provided by A.R.S. § 20-1060. The filing of such returns or payment of such tax may be adjusted or waived by the Director upon application and affirmative showing in writing therefor justifying the adjustment or waiver.~~
6. ~~The Director may, upon written request accompanied by supporting documentation justifying the request, authorize the substitution of public information filed by an applicant under similar statutes or regulations in another state, or under federal requirements, or may waive such information or additional information.~~
7. ~~Pursuant to the authority of A.R.S. § 20-1053(13), the Director finds that biographical information disclosing the past activities, employment and financial transactions or principals, principal officers, controlling persons, and agents of applicant Health Care Services Organizations is necessary for the protection of residents of this State.~~
8. ~~Pursuant to the authority of A.R.S. § 20-1053(13), the Director finds that records of fingerprints of principal officers and agents of applicant Health Care Services Organizations may be necessary for the protection of citizens of this state and may be required prior to licensing or approval of a Certificate of Authority.~~

~~H. Certificate of Authority – Application. The application for Certificate of Authority shall be accompanied by a power of attorney as required by A.R.S. § 20-1053(A)(10), on Department Form E-128.~~

~~I.~~**E.** Certificate of Authority – Grounds for denial

1. Policy. A Certificate of Authority to operate a Health Care Services Organization shall not be granted until the Director is satisfied by the affirmative showing, verified by the applicant, that all of the requirements of A.R.S. §§ 20-1051, 20-1052, 20-1052.01, 20-1053 and 20-1054 are met and will continue to be met.
2. Guidelines. The guidelines and standards for determination of appropriate mechanisms to achieve an effective Health Care Plan include, but are not limited to the following:
   a. Ability to provide basic Health Care Services without undue restrictions, limitations, discrimination, unreasonable fee schedules, or unreasonable administrative costs; an affirmative showing that the form of organization does not evidence any coercion, duress or other compulsion over members;
   b. The form of organization does not lend itself to practices prohibited by A.R.S. §§ 20-441 through 20-459, and
   c. The evidence of coverage does not contain provisions or statements which are unjust, inequitable, misleading, deceptive or untrue or encourage ~~misrepresentation.~~ misrepresentation.
3. Failure to pay obligations. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected if the applicant has failed after 30 days from the entry of final judgment, to pay obligations within the provisions of an evidence of coverage issued by such applicant. The provisions of this Section may be waived by the Director upon a clear affirmative showing that the applicant is defending an action or appealing a judgment at law or equity in a court of this state, or is required to obtain a Certificate of Authority so as to maintain such action.
4. ~~Unauthorized agents. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected, after stated cause and opportunity to answer, if the applicant has, 90 days after the effective date, permitted transactions by an unauthorized agent.~~

~~J.~~**F.** Solicitation requirements

1. ~~Forms for evidences of coverage, advertising matter, sales material and amendments thereto, will not be approved until the Director is satisfied by filing of Department Form P-107 accompanying the filing of such form and the payment of necessary fees, that the requirements of A.R.S. §§ 20-1057, 20-1054(2), and 20-1061 have been met and will continue to be met.~~ Forms for evidences of coverage, advertising matter, sales material and amendments thereto will not be approved until the Director is satisfied all applicable statutory requirements have been met and will continue to be met, and the necessary fees have been paid.
2. Each Health Care Services Organization shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement brochure, form letter of solicitation, evidence of coverage, certificate, agreement or contract, and a copy of all radio and television forms of the above hereafter disseminated in this or any other ~~State~~ state with a notation attached to each such solicitation or inducement to indicate the manner and extent of distribution and the date of approval by the Department of such solicitation. Such advertising file shall be maintained for a period of not less than three years.

~~K. Annual report. Each Health Care Services Organization required to file an annual statement, shall, on or before March 1 of each year, file with the Director, together with its annual statement on Department Form E-13, a certificate executed by an authorized officer of the Health Care Services Organization stating that to the best of his knowledge, information and belief, all written solicitations disseminated during the preceding statement year complied or were made to comply with the provisions of Title 20, Chapter 4, Article 9, and this rule, and that no forms of solicitation were disseminated without the prior approval of the Director.~~

~~L.~~**G.** Taxes

1. All Health Care Services Organizations operating and transacting business in the State of Arizona shall on or before March 1 and with the filing of the Annual Report, file a tax return ~~on Department Form E-162,~~ and pay the tax due on ~~such~~ the filed return pursuant to A.R.S. § 20-1060.
2. ~~A tax return required to be filed and filed with an application for Certificate of Authority may cover a period of time of less than a calendar year as specified in the return and approved by the Director.~~ Annual tax returns required to be filed coincident with the annual report shall be for the full calendar year next preceding the date of filing the annual report.
3. Net charges, as in this ~~rule~~ Section defined, shall represent the net charges received during the calendar year next preceding the date of filing the annual report and tax return.

~~M.~~**H.** Deposit requirements

1. In the event a Health Care Services Organization determines to maintain statutory deposits by a surety bond, such surety bond shall be ~~in~~ on a form as approved by the Director guaranteeing the payment of Health Care Services furnished to enrollees, and shall be deposited with the State Treasurer.
2. ~~In the event a Health Care Services Organization determines to maintain the deposit requirements by filing securities with the State Treasurer, a full and complete statement of the securities proposed to be deposited, together with sufficient information to permit a determination of eligibility of such securities shall be filed with the Director on Department Form E-123, and such securities shall not be deposited until such securities are approved by the Director in writing.~~
   Provider sponsored Health Care Services Organizations claiming to be exempt from the deposit requirement, pursuant to A.R.S. § 20-1055(F), shall submit to the Director an affirmative showing or certification executed by an authorized federal, state or municipal government or political subdivision thereof, demonstrating operational commitments equivalent to the statutory deposit requirements.
3. ~~No securities deposited as herein provided shall be exchanged or substituted for similar securities, except upon the prior written approval of the Director.~~
   Statutory deposits shall not be withdrawn or a surety bond cancelled until all contingent and perfected liens, including judgments, debts, and other liabilities for payment of Health Care Services to which the enrollee is entitled under the evidence of coverage, shall have been paid and the Director authorizes, in writing, to withdraw such deposits or cancel such bonds. Equal par value statutory deposit exchanges may be completed without the Director's prior approval.
4. ~~Health Care Services Organizations claiming to be exempt from the deposit requirement, pursuant to A.R.S. § 20-1055(f) shall submit to the Director an affirmative showing or certification executed by an authorized federal, state or municipal government or political subdivision thereof, demonstrating operational commitments equivalent to the statutory deposit requirements.~~

~~5. Statutory deposits shall not be withdrawn or a surety bond cancelled until all contingent and perfected liens, including judgments, debts, and other liabilities for payment of Health Care Services to which the enrollee is entitled under the evidence of coverage shall have been paid and the Director has given his authority in writing to withdraw such deposits or cancel such bonds.~~

~~**N.** Reserve requirements. Reserves required by A.R.S. § 20-1056 shall be deposited or maintained as cash, as Certificates of Deposit, or as securities eligible for investment of the capital of domestic insurers, pursuant to A.R.S. §§ 20-537 and 20-538.~~

~~**O.**~~**I.** Insurers and hospital and medical service corporations – Certificate of Authority

1. Insurers, Hospital Service Corporation, Medical Service Corporations, and Hospital and Medical Service Corporations, holding current Certificates of Authority to do business in this state may organize and operate Health Care Services Organizations jointly or severally without compliance with the deposit and reserve requirements of the statute~~,~~ if the application contains an affirmative showing that the applicant organization has complied with comparable provisions of Title 20, and is an appropriate mechanism to achieve an effective Health Care Plan.
2. The provisions of statute and this ~~rule~~ Section applying to Certificates of Authority and Application therefor, shall apply to all insurers, Hospital Service Corporations, Medical Service Corporations, and Hospital and Medical Service Corporations doing business in this state.
3. Organizations claiming exemption or partial exemption pursuant to ~~A.R.S. § 20-1063(c)~~ A.R.S. § 20-1063(C) shall file with the Director simultaneously with the application for Certificate of Authority, a statement affirmatively showing that the applicant has complied with provisions of Title 20 A.R.S. comparable to or more restrictive than the provisions of Title 20, Chapter 4, Article 9, and shall have received the written approval of the Director for such exemption or partial exemption.

~~**P.** Application, examination and licensing of agents~~

~~1. No agent of a Health Care Services Organization shall be eligible for transactions of a Health Care Services Organization, unless, prior to making any solicitation or transaction, he has been appointed agent by a Health Care Services Organization holding a current valid Certificate of Authority and has been licensed as herein provided. Persons directly or indirectly representing or acting for a Health Care Services Organization and not licensed as herein provided, or otherwise qualified under A.R.S. Title 20, shall be an unqualified agent.~~

~~2. Any person applying for a license as an agent of a Health Care Services Organization shall do so by filing with the Department of Insurance the following:~~

~~a. An application for such license on a form approved by the Director of the Department of Insurance;~~

~~b. The required fees for such license;~~

~~c. Such additional information as the Director may deem necessary.~~

~~3. The licensing of an agent of a Health Care Services Organization shall not become effective until such applicant shall have satisfactorily passed a written examination in accordance with A.R.S. § 20-292 as supplemented by A.R.S. § 20-167.~~

~~4. The examination shall be given in such places and at such times as the Director shall from time to time designate.~~

~~5. The form of examination and the manual may be altered and amended from time to time, so as to represent a fair test of the applicant's qualifications.~~

~~6. Every applicant for license shall satisfactorily complete the examination given with a grade of at least 70%, or such other percentage as may be fixed from time to time by the Director prior to the examination commensurate with the nature of the examination given.~~

~~7. License and examination fees shall be in accordance with A.R.S. § 20-167.~~

~~8. Report of the results of any examination given pursuant to this rule shall be mailed to the applicant and to the applicant's Health Care Services Organization at the address shown on the application.~~

~~9. Except as modified by this rule, the provisions for examination, licensing, annual fees and disciplinary procedures of Chapter 2, Article 3 of Title 20, shall apply.~~

~~10. Any agent licensed in this state shall immediately report to the Director any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or other violation affecting his license and all complaints or charges of misconduct lodged with his employer, any public agency of the state, or another state.~~

~~11. The Director may reject any application or suspend or revoke, or refuse to renew any agent's license for inducements or statements which are unjust, unfair, inequitable, misleading or deceptive, or which encourage misrepresentation, or are untrue or misleading.~~

~~12. The rules, standards and guidelines governing any proceeding relating to the suspension or revocation of the license of a life insurance agent, where applicable, shall also govern any proceedings for suspension or revocation of the license of an agent of a Health Care Services Organization.~~

~~13. Renewal of a license of an agent shall follow the same procedure as heretofore established for renewal of insurance agents' licenses in this state.~~

~~14. Renewal of a license of an agent shall follow the same procedure as heretofore established for renewal of insurance agents' licenses in this state.~~

J. Application, examination and licensing of agents. No agent of a Health Care Services Organization shall be eligible for transactions of a Health Care Services Organization unless, prior to making any solicitation or transaction, the agent has been appointed by a Health Care Services Organization holding a current valid Certificate of Authority and is licensed as an insurance producer. The Health Care Services Organization is not required to report its appointments to the Department. An agent directly or indirectly representing or acting for a Health Care Services Organization and not licensed or otherwise qualified under A.R.S. Title 20, shall be an unqualified agent.

~~**Q.**~~**K.** Forms

1. The forms prescribed by this ~~rule~~ Section and ~~the instructions applicable thereto~~ their instructions are adopted as requirements of the Director and necessary for the protection of citizens of this state. Such forms, instructions, manuals or examinations are those currently in use, but the same may be amended and approved without reference to this ~~rule~~ Section ~~and when approved as~~

~~amended are incorporated in this rule by reference~~. The form of manual or examination of agents, or any form adopted by the Director may be reproduced for the purpose of reporting or for other purposes.

2. For good cause shown, the Director may authorize the filing of forms and reports on dates other than required by this ~~rule,~~ Section, if applied for in writing not less than 10 days prior to the due date of ~~such~~ the report and statement, exhibit, return or accounting.

~~R.~~**L.** Severability. In any provision of this ~~rule~~ Section or the forms, statements, returns or reports made part of this ~~rule,~~ Section, or the application ~~thereof~~ to any person or circumstance is held invalid, such invalidity shall not affect the provisions of applications of this ~~rule,~~ Section, which can be given effect without the invalid provision or application, and to this end the provisions of this ~~rule~~ Section are declared to be severable.

~~S. Effective date. This rule became effective on the 7th day of May, 1973. Amendments to this rule shall become effective upon filing with the Secretary of State.~~

R20-6-409. Hospital, Medical, Dental, and Optometric Service Corporations

A. Applicability. This rule applies to all subscription contracts issued by hospital, medical, dental and optometric service corporations.

B. Subscription contract provision. Subscription contracts of hospital, medical, dental and optometric service corporations subject to the provisions of Article 3, Chapter 4 of Title 20, A.R.S., shall meet the requirements of the following ~~rules:~~ Sections:

1. R20-6-201. Advertisements of ~~disability insurance.~~ Health,
2. ~~R20-6-209. Unfair sex discrimination.~~ R20-6-207. Gender Discrimination,
3. ~~R20-6-210. Group coverage discontinuance and replacement.~~ R20-6-208. Group Coverage Discontinuance and Replacement,
4. ~~R20-6-213. Unfair discrimination on the basis of blindness, partial blindness, or physical disability.~~ R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness,
5. ~~R20-6-216. Life and disability insurance policy language simplification.~~ R20-6-213. Life and Disability Insurance Policy Language Simplification, and
6. ~~R20-6-302. Valuation of reserves for disability policies.~~ R20-6-607. Reasonableness of Benefits in Relation to Premium Charged.
7. ~~R20-6-606. Medicare supplement insurance disclosure and minimum standards.~~
8. ~~R20-6-607. Reasonableness of benefits in relation to premium charged.~~

~~C. Severability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.~~

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS INSURANCE DIVISION

[R23-230]

PREAMBLE

1. Article, Part, or Section Affected (as applicable) — **Rulemaking Action**

R20-6-205	Amend
R20-6-604	Amend
R20-6-801	Amend
R20-6-1003	Amend
Appendix B	Amend
R20-6-2002	Amend
R20-6-2401	Amend

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 20-143(A)

Implementing statutes: R20-6-205: A.R.S. § 20-230(A); R20-6-604: A.R.S. § 20-1615; R20-6-801: A.R.S. § 20-461(C); R20-6-1003 and Appendix B: A.R.S. § 20-1691.02; R20-6-2002: A.R.S. § 20-1098.14; R20-6-2401: A.R.S. § 20-142(B); A.R.S. §§ 20-3111 through 20-3119

3. The effective date of the rule:

January 7, 2024

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 1204, May 26, 2023
Notice of Proposed Rulemaking: 29 A.A.R. 1173, May 26, 2023

5. The agency's contact person who can answer questions about the rulemaking:

Name: Mary E. Kosinski
Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, AZ 85007-2630
Telephone: (602) 364-3476
Email: mary.kosinski@difi.az.gov
Website: https://difi.az.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Arizona Department of Insurance and Financial Institutions – Insurance Division ("Department") is proposing housekeeping changes to A.A.C. Title 20, Chapter 6, Sections R20-6-205, R20-6-604, R20-6-801, R20-6-1003 and Appendix B, R20-6-2002, and R20-6-2401.

The Department's changes are necessary to accurately reflect the correct name of the Department which changed in 2020, to clarify the title of one Section, to correct statutory references, to correct typographical errors, and to remove some archaic language. The Department is proposing the following changes:

- Article 2. Transaction of Insurance: Section R20-6-205 (Local or Regional Retaliatory Tax Information) will be amended to correct the name of the Department in subsection (A). This correction also fulfills a commitment made in the Department's 2021 Five-Year Review Report.
- Article 6. Types of Insurance Contracts: Section R20-6-604 (Definitions) will be amended to change the title of the Section to "Consumer Credit Insurance; Definitions" to indicate that this Section and the following Sections (R20-6-601.01 through R20-6-601.10) pertain to Consumer Credit Insurance, to eliminate redundant statutory definitions, and to add numbers to the definitions for clarity. This correction also fulfills a commitment made in the Department's 2020 Five-Year Review Report.
- Article 8. Prohibited Practices, Penalties: Section R20-6-801 (Unfair Claims Settlement Practices) will be amended to revise the definitions for "agent" and "Director", to add a definition for "Department," to update antiquated language, and to revise to meet rule writing standards and promote clarity. This correction also fulfills a commitment made in the Department's 2023 Five-Year Review Report.
- Article 10. Long-term Care Insurance: Section R20-6-1003 (Policy Terms) will be amended to correct statutory references in two definitions. Appendix B (Long-term Care Insurance Potential Race (sic) Increase Disclosure Form) will be amended to correct a typographical error in the title of the Appendix. This correction also fulfills a commitment made in the Department's 2018 and 2023 Five-Year Review Reports to correct errors when found.
- Article 20. Captive Insurers: R20-6-2002 (Fees; Examination Costs) will be amended to correct a statutory reference in subsection (A).
- This correction also fulfills a commitment made in the Department's 2021 Five-Year Review Report.
- Article 24. Out-of-Network Claim Dispute Resolution: R20-6-2401 (Definitions) will be amended to correct the name of the Department to its current name.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review and does not propose to rely on any study relevant to this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

The rulemaking does not diminish a previous grant of authority granted to the Department.

9. The summary of the economic, small business, and consumer impact:

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct. Instead, it is necessary to perform some housekeeping required when the Department changed its name in 2020 and to fulfill a commitment made by the Department in a 2021 Five-Year Review Report. The proposed changes should make compliance with these Sections less confusing for regulated entities.
- Because this rulemaking is not made in response to a perceived problem caused by the conduct of licensees, it is not intended to reduce the frequency of any potentially violative conduct.

Pursuant to A.R.S. § 41-1055(A)(2):

- The Department does not anticipate any additional costs to be incurred by licensees.
- The person listed in Item 5 may be contacted to submit or request additional data on the information included in the economic, small business and consumer impact statement.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department has made a typographical correction to subsection R20-6-801(D)(4) at the fourth line from:

"4. No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if ~~such~~ the a time limit is not complied with unless the failure to comply with ~~such~~ the time limit prejudices the insurer's rights."

to:

"4. No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if ~~such a~~ the time limit is not complied with unless the failure to comply with ~~such~~ the time limit prejudices the insurer's rights."

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department published the Notice of Proposed Rulemaking for these Sections on May 26, 2023. (29 A.A.R. 1173, May 26, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters prescribed by statute are applicable to the Department or to any specific rule or class of rules.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

None of the Sections being revised require a permit.

Section R20-6-604 pertains to Consumer Credit Insurance which is a type of insurance issued by an insurer holding a Certificate of Authority in Arizona.

Section R20-6-1003 and Appendix B pertain to Long-term Care Insurers who hold a Certificate of Authority in Arizona.

Section R20-6-2002 pertains to Captive Insurers who hold a license to transact captive insurance from the Department pursuant to A.R.S. § 20-1098.01.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Article 24. Out-of-Network Claim Dispute Resolution and Section R20-6-2401 pertain to "Surprise Billing." Surprise Billing (also called balance billing) occurs when an insured person receives health care services from a provider who is not contracted with the insured person's network to provide services. The statutory sections pertaining to Surprise Billing are found at A.R.S. §§ 20-3111 through 20-3119.

In 2021, the Federal government passed the "No Surprises Act" (Consolidated Appropriations Act, 2021, Public Law 116-260). The No Surprises Act (the "Federal law") became effective for plans issued on or after January 1, 2022. The Federal law provides to consumers much of the same functions and protections of Arizona's Surprise Billing Act (the "Arizona law"). However, the Arizona law does not offer its protections to all persons enrolled in health plans and has a dollar limitation. Therefore, the Arizona law is more stringent than the Federal law. Consequently, the Arizona law will eventually be pre-empted in its entirety by the Federal law once all potential appeals for plans renewed in 2022 are expired. The Department estimates that this pre-emption will occur sometime in 2024. Further information is available on the Department's website at: https://difi.az.gov/soonbdr and on the CMS website at: https://www.cms.gov/nosurprises.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None of the rules being amended incorporate reference material.

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable. None of the Sections being amended in this rulemaking were previously made, amended or repealed as an emergency rule.

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS INSURANCE DIVISION

ARTICLE 2. TRANSACTION OF INSURANCE

Section
R20-6-205. Local or Regional Retaliatory Tax Information

ARTICLE 6. TYPES OF INSURANCE CONTRACTS

Section
R20-6-604. ~~Definitions~~ Consumer Credit Insurance; Definitions

ARTICLE 8. PROHIBITED PRACTICES, PENALTIES

Section
R20-6-801. Unfair Claims Settlement Practices

ARTICLE 10. LONG-TERM CARE INSURANCE

Section
R20-6-1003. Policy Terms
Appendix B. Long-term Care Insurance Potential ~~Race~~ Rate Increase Disclosure Form

ARTICLE 20. CAPTIVE INSURERS

Section
R20-6-2002. Fees; Examination Costs

ARTICLE 24. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

Section
R20-6-2401. Definitions

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-205. Local or Regional Retaliatory Tax Information

A. Definitions.
1. "Addition to the rate of tax" means the tax rate determined under subsection (D) to be applied under A.R.S. 20-230(A) and this Section to foreign or alien insurers domiciled in a foreign country or other state that impose local or regional taxes.
2. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
3. "Arizona life insurer" means a domestic insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
4. "Department" means the Arizona Department of Insurance~~.~~ and Financial Institutions.
5. "Director" has the meaning prescribed in A.R.S. § 20-102.
6. "Domestic insurer" has the meaning prescribed in A.R.S. § 20-203.
7. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.
8. "Foreign or alien life insurer" means a foreign or alien insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
9. "Local or regional taxes" means any tax, license, or other obligation imposed upon domestic insurers or their producers by any:
   a. City, county, or other political subdivision of a foreign country or other state; or
   b. Combination of cities, counties, or other political subdivisions of a foreign country or other state.
10. "Other Arizona insurer" means a domestic insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
11. "Other foreign or alien insurer" means a foreign or alien insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
12. "Other state" means any state in the United States, the District of Columbia, and territories or possessions of the United States, excluding Arizona.
13. "Premium Tax and Fees Report," includes the "Survey of Arizona Domestic Insurers" and the "Retaliatory Taxes and Fees Worksheet," and means the form prescribed by the Director and filed annually by insurers under A.R.S. § 20-224.

B. Scope. This Section applies to all foreign, alien, and domestic insurers and to Premium Tax and Fees Reports filed by all insurers.

C. Data to be reported by domestic insurers. As a part of its Premium Tax and Fees Report, each domestic insurer shall file a Survey of Arizona Domestic Insurers that reports the following data for the calendar year covered by the insurer's Premium Tax and Fees Report with respect to each foreign country or other state in which the insurer was required to pay any local or regional taxes:
1. Total local or regional taxes paid; and
2. Total premiums taxed under the premium taxing statute of the foreign country or other state, as reported by the insurer in any premium tax report filed under the laws of the foreign country or other state.

D. Computation of statewide and foreign countrywide additions to the rate of tax. For each foreign country or other state having one or more local or regional taxes on domestic insurers, the Department shall compute on a statewide or foreign countrywide basis an addition to the rate of tax. The Department shall compute the addition to the rate of tax payable by Arizona life insurers separately from the addition to the rate of tax payable by other Arizona insurers. The addition to the rate of tax payable by each category of Arizona domestic insurers shall be the quotient of:
1. The aggregate local or regional taxes reported as paid to the foreign country or other state by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report divided by,

2. The aggregate statewide or foreign countrywide premiums taxed under the premium taxing statute of the other state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.

E. Publication of additions to the rate of tax. The Department shall publish additions to the rate of tax determined under A.R.S. § 20-230(A) and this Section, based upon the survey information gathered from domestic insurers for the preceding calendar year under subsection (C). The Department shall publish the information annually on the Department web site, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.

F. Foreign and Alien Insurers' Report of the Effect of Local or Regional Taxes. Each foreign or alien insurer domiciled in a foreign country or other state for which the Department publishes an addition to the rate of tax shall include in the "State or Country of Incorporation" column of its Retaliatory Taxes ~~And~~ and Fees Worksheet for the calendar year covered by its Premium Tax and Fees Report an amount equal to:

1. The total premiums received in Arizona that would be taxed under the laws of the domiciliary jurisdiction, as reported in the "State or Country of Incorporation" column of its premium tax and fees report multiplied by,
2. The applicable addition to the rate of tax published by the Department for the calendar year covered by the insurer's Premium Tax and Fees Report.

G. Contesting computation. A foreign or alien insurer subject to this Section may preserve the right to contest the computation of the addition to the rate of tax by submitting a notice of appeal under A.R.S. Title 41, Chapter 6, Article 10 before or at the time the retaliatory tax is paid. Subject to A.R.S. § 20-162, the filing of a notice of appeal to contest the computation of the applicable addition to the rate of tax does not relieve a foreign or alien insurer of the obligation to timely pay the retaliatory tax, and does not stay accrual of any applicable interest and penalties.

ARTICLE 6. TYPES OF INSURANCE CONTRACTS

R20-6-604. ~~Definitions~~ Consumer Credit Insurance; Definitions

The definitions in A.R.S. § 20-1603 and this Section apply to R20-6-604 through R20-6-604.10.

1. "Actual loss ratio" means incurred claims divided by earned premiums at rates in use.
2. "Actuarially equivalent" means of equal actuarial present value determined as of a given date with each value based on the same set of actuarial assumptions. When used in this Article in reference to rates and coverage, "actuarially equivalent" means a rate or coverage that is actuarially determined to yield loss ratios of 50% for credit life insurance and 60% for credit disability insurance.
3. "Credit insurance" means credit life insurance, credit disability insurance, or both, but does not include any insurance for which there is no identifiable charge.
4. "Earned premiums" means earned premiums at prima facie rates and earned premiums at rates in use.
5. "Earned premiums at prima facie rates" means an insurer's actual earned premiums, adjusted to the amount that the insurer would have earned if the insurer's premium rates had equaled the prima facie rates in effect during the experience period.
6. "Earned premiums at rates in use" means the premiums that an insurer actually earns on the premium rates the insurer charges during an experience period.
7. "Evidence of individual insurability" means information about a debtor's health status or medical history that a debtor provides as a condition of credit insurance becoming effective.
8. "Experience" means an insurer's earned premiums and incurred claims during an experience period.
9. "Experience period" means a period of time for which an insurer reports income and expense information on the insurer's credit insurance business.
10. "Final adjusted rates" means the prima facie rates referred to in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08.
    ~~"Gross debt" means the sum of the remaining payments that a debtor owes a creditor.~~
    ~~"Identifiable charge" means a charge for credit insurance that is imposed on a debtor with credit insurance but not on a debtor without credit insurance, and includes a charge for insurance that is disclosed in the credit or other financial instrument furnished to the debtor, which sets forth the financial elements of a credit transaction, and any difference in finance, interest, service charges, or other similar charges made to a debtor in like circumstances except for the debtor's status as insured or noninsured.~~
11. "Incurred claims" means the total claims an insurer pays during an experience period, adjusted for the change in the claim reserves.
    ~~"Net debt" means the amount necessary to liquidate a debt in a single lump-sum payment excluding unearned interest and other unearned finance charges.~~
12. "Plan of credit insurance" means an insurance plan based on one of the following rate and coverage categories:
    a. Credit life insurance, other than on revolving accounts, including joint and single life coverage, decreasing and level insurance, and outstanding balance and single premium;
    b. Credit life insurance on revolving accounts;
    c. Credit life insurance on an age-graded basis;
    d. Credit disability insurance, other than on revolving accounts, including outstanding balance and single premium, and each combination of waiting period and retroactive or non-retroactive benefits;
    e. Credit disability insurance on revolving accounts, including each combination of waiting period and retroactive or non-retroactive benefits.
13. "Preexisting condition" means a condition:
    a. For which a debtor received medical advice, consultation, or treatment within six months before the effective date of credit insurance coverage; and
    b. From which the debtor dies, in the case of life insurance, or becomes disabled, in the case of disability insurance, within six months after the effective date of coverage.
14. "Prima facie adjusted loss ratio" means incurred claims divided by earned premiums at prima facie rates.

15. "Prima facie rates" means the rates established by the Director as prescribed in R20-6-604.03.
16. "Reasonableness standard" means the requirement in A.R.S. § 20-1610(B) that an insurer's premiums for credit insurance shall not be excessive in relation to the benefits provided under the policy.
17. "Rule of Anticipation" means the product of the gross single premium per $100 of indebtedness for a debtor's remaining term of indebtedness, times the number of hundreds of dollars of remaining indebtedness.

ARTICLE 8. PROHIBITED PRACTICES, PENALTIES

R20-6-801. Unfair Claims Settlement Practices

A. Applicability. This rule applies to all persons and to all insurance policies, insurance contracts and subscription contracts except policies of Worker's Compensation and title insurance. This rule is not exclusive, and other acts not herein specified, may also be deemed to be a violation of A.R.S. § 20-461, The Unfair Claims Settlement Practices Act.

B. Definitions

1. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim. "Agent" has the same meaning as "Insurance producer" as defined at A.R.S. § 20-281(5).
2. "Claimant" means either a first party claimant, a third party claimant, or both and includes ~~such~~ the claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.
3. ~~"Director" means the Director of Insurance of the State of Arizona.~~
   "Department" means the Arizona Department of Insurance and Financial Institutions – Insurance Division.
4. ~~"First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency of loss covered by such policy or contract.~~
   "Director" has the meaning of A.R.S. § 20-102.
5. ~~"Insurance policy or insurance contract" has the meaning of A.R.S. § 20-103.~~
   "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency of loss covered by the policy or contract.
6. ~~"Insurer" has the meaning of A.R.S. § 20-106(C).~~
   "Insurance policy or insurance contract" has the meaning of A.R.S. § 20-103.
7. ~~"Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.~~
   "Insurer" has the meaning of A.R.S. § 20-106(C).
8. ~~"Notification of claim" means any notification, whether in writing or other means, acceptable under the terms of any insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.~~
   "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.
9. ~~"Person" has the meaning of A.R.S. § 20-105.~~
   "Notification of claim" means any notification, whether in writing or other means, acceptable under the terms of any insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.
10. ~~"Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.~~
    "Person" has the meaning of A.R.S. § 20-105.
11. ~~"Worker's compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.~~
    "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.
12. "Worker's compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.

C. File and record documentation. The insurer's claim files shall be subject to examination by the Director or by his duly appointed designees. ~~Such~~ The files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of ~~such~~ the events can be reconstructed.

D. Misrepresentation of policy provisions

1. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.
2. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when ~~such~~ the benefits, coverages or other provisions are pertinent to a claim.
3. No insurer shall deny a claim on the basis that the claimant has failed to exhibit the damaged property to the insurer, unless the insurer has requested the claimant to exhibit the property and the claimant has refused without a sound basis. ~~therefor.~~
4. No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if ~~such a~~ the time limit is not complied with unless the failure to comply with ~~such~~ the time limit prejudices the insurer's rights.
5. No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

6. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language that releases the insurer or its insured from its total liability.

E. Failure to acknowledge pertinent communications

1. Every insurer, upon receiving notification of a claim shall, within 10 working days, acknowledge the receipt of ~~such~~ the notice unless payment is made within ~~such period of time.~~ the 10 working days. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.
2. Every insurer, upon receipt of any inquiry from the Department ~~of Insurance~~ respecting a claim shall, within ~~fifteen~~ 15 working days of receipt of ~~such~~ the inquiry, furnish the Department with an adequate response to the inquiry.
3. An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
4. Every insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with subsection (E)(1).

F. Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless ~~such~~ the investigation cannot reasonably be completed within ~~such time.~~ 30 days.

G. Standards for prompt, fair and equitable settlements applicable to all insurers

1. Notice of acceptance of denial of claim.
   a. Within ~~fifteen~~ 15 working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to ~~such~~ the provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.
   b. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall also notify the first party claimant within ~~fifteen~~ 15 working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the date of the initial notification and every 45 days thereafter, send to ~~such~~ the claimant a letter setting forth the reasons additional time is needed for investigation.
   c. Where there is a reasonable basis supported by specific information available for review by the Director for suspecting that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of subsections (G)(1)(a) and (b). Provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.
2. If a claim is denied for reasons other than those described in ~~subsections~~ subsection (G)(1)(a), and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.
3. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.
4. Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's right. ~~Such~~ The notice shall be given to first party claimants 30 days, and to third party claimants 60 days, before the date on which ~~such~~ the time limit may expire.
5. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

H. Standards for prompt, fair and equitable settlements applicable to automobile insurance

1. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:
   a. The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection ~~thereof~~ of the offer must be documented in the claim file.
   b. The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. ~~Such~~ The cost may be determined by:
      i. The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area.
      ii. One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.
   c. When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections (H)(1)(a) and (b), the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from ~~such~~ the cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for ~~such~~ the settlement shall be fully explained to the first party claimant.
2. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under ~~such~~ the insurer's policy or insurance contract.

3. Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate, or to have the automobile repaired at a specific repair shop.
4. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect ~~such~~ the deductible recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.
5. If an insurer prepares an estimate of the cost of automobile repairs, ~~such~~ the estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.
6. When the amount claimed is reduced because of betterment or depreciation, all information for ~~such~~ the reduction shall be contained in the claim file. ~~Such deductions~~ The reductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of ~~deductions.~~ reductions.
7. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.
8. The insurer shall not use as a basis for cash settlement with a first party claimant an amount which is less than the amount which the insurer would pay if the repairs were made, other than in total loss situations, unless ~~such~~ the amount is agreed to by the insured.

I. Severability. If any provision of this ~~rule~~ Section or ~~the application thereof~~ its application to any person or circumstances is held invalid, the remainder of the ~~rule~~ Section and the application of ~~such~~ the provision to other persons and circumstances shall not be affected.

~~**J.** Effective date. This rule shall become effective 90 days from the date of filing with the Secretary of State.~~

ARTICLE 10. LONG-TERM CARE INSURANCE

R20-6-1003. Policy Terms

A. A long-term care insurance policy delivered or issued for delivery in this state shall not use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:
1. "Activities of daily living" means eating, toileting, transferring, bathing, dressing, or continence.
2. "Acute condition" means that an individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status.
3. "Adult day care" means a program of social and health-related services for six or more individuals, that is provided during the day in a community group setting, for the purpose of supporting frail, impaired, elderly, or other disabled adults who can benefit from the services and care in a setting outside the home.
4. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).
5. "Bathing" means washing oneself by sponge bath, or in a tub or shower, and includes the act of getting in and out of the tub or shower.
6. "Chronically ill individual" has the meaning prescribed for this term by A.R.S. § 20-1691(3) and Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended.
   a. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
      i. Being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to loss of functional capacity; or
      ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
   b. The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
7. "Cognitive impairment" means a deficiency in a person's:
   a. Short or long-term memory;
   b. Orientation as to person, place, or time;
   c. Deductive or abstract reasoning; or
   d. Judgment as it relates to safety awareness.
8. "Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control, the ability to perform associated personal hygiene, such as caring for a catheter or colostomy bag.
9. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
10. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table, or by a feeding tube or intravenously.
11. "Guaranteed renewable" means the insured has the right to continue a long-term-care insurance policy in force by the timely payment of premiums and the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that the insurer may revise rates on a class basis.
12. "Hands-on assistance" means physical help to an individual who could not perform an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.
13. "Home health services" means the services described at A.R.S. § 36-151.
14. "Level premium" means that an insurer does not have any right to change the premium, even at renewal.
15. "Licensed health care practitioner" has the same meaning as ~~A.R.S. § 20-1691(7).~~ A.R.S. § 20-1691(6).
16. "Maintenance or personal care services" has the same meaning as A.R.S. § 20-1691(10).

17. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
18. "Noncancellable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally cancel or make any change in any provision of the insurance or in the premium rate.
19. "Personal care" means the provision of hands-on assistance to help an individual with activities of daily living in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
20. "Qualified long-term care services" has the meaning prescribed for this term under ~~A.R.S. § 20-1691(14)~~ A.R.S. § 20-1691(13) and means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
21. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing tasks associated with personal hygiene.
22. "Transferring" means moving into or out of a bed, chair, or wheelchair.

B. Any long-term care policy delivered or issued for delivery in this state shall include the following policy terms and provisions as specified in this subsection:

1. "Home care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
2. "Intermediate care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
3. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
4. "Skilled nursing care," "specialized care," "assisted living care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is delivered.
5. Service providers, including "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility" and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

Appendix B. Long-term Care Insurance Potential ~~Race~~ Rate Increase Disclosure Form

Instructions:
This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]**: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application][$_____])
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy**.
3. **Rate Schedule Adjustments**:
   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.
4. **Potential Rate Revisions**:
   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- ☐ Pay the increased premium and continue your policy in force as is.
- ☐ Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- ☐ Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- ☐ Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**
If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:
You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%

84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

ARTICLE 20. CAPTIVE INSURERS

R20-6-2002. Fees; Examination Costs

A. A corporation applying for a license to do business as a captive insurer~~, under A.R.S. § 20-1098,~~ shall pay a nonrefundable fee of $1,000.00 to the Department for issuance of the license~~.~~ under A.R.S. § 20-1098.01(J). A captive insurer that is a protected cell captive insurer, as defined in A.R.S. § 20-1098, also shall pay to the Department a nonrefundable fee of $1,000 for each participant contract application that establishes a protected cell under A.R.S. § 20-1098.05(B)(9). The fee is payable in full at the time the applicant submits the application for license to the Department under A.R.S. § 20-1098.01.

B. A captive insurer shall pay a nonrefundable annual renewal fee of $5,500.00 to the Department at the time of filing its annual report under A.R.S. § 20-1098.07. Under A.R.S. § 20-1098.01(J), a captive insurer that is a protected cell captive insurer also shall pay to the Department a nonrefundable annual renewal fee of $2,500.00 for each protected cell at the time of filing its annual report under A.R.S. § 20-1098.07.

C. A captive insurer shall pay a nonrefundable fee of $200.00 to the Department at the time of filing for issuance of an amended certificate of authority.

D. In addition to the fees prescribed in subsections (A)~~,~~ ~~and~~ (B), and (C), an applicant for a captive insurer license or a licensed captive insurer shall pay the costs of any examination the Director conducts, under A.R.S. § 20-1098.08.

ARTICLE 24. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

R20-6-2401. Definitions

The definitions in A.R.S. § 20-3111 and this Section apply to this Article.

1. "Allowed Amount" is the amount reimbursable for a covered service under the terms of the enrollee's benefit plan. The allowed amount includes both the amount payable by the insurer and the amount of the enrollee's cost sharing requirements.
2. "Alternative Arbitrator" is an individual who is mutually agreeable to the health insurer and health care provider to act as the arbitrator of a surprise out-of-network billing dispute. If the person is contracted with the State of Arizona to conduct arbitration proceedings, the provisions of that contract shall apply. Department staff may not serve as an Alternative Arbitrator.
3. "Amount of the enrollee's cost sharing requirements" means the amount determined by the insurer prior to the dispute resolution process to be owed by the enrollee for out-of-network copayment, coinsurance and deductible pursuant to the enrollee's health care policy.
4. "Arbitrator" has the same meaning as A.R.S. § 20-3111(2) and may include a mediator, arbitrator or other alternative dispute resolution professional who is contracted with the Department to arbitrate a surprise out-of-network billing dispute. Department staff may not serve as an Arbitrator.
5. "A.R.S. § 20-3113 Disclosure" means a written, dated document that contains the following information:
   a. The name of the billing health care provider;
   b. A statement that the health care provider is not a contracted provider;
   c. The estimated total cost to be billed by the health care provider or the provider's representative for the health care services being provided;
   d. A notice that the enrollee or the enrollee's authorized representative is not required to sign the A.R.S. § 20-3113 Disclosure to obtain health care services;
   e. A notice that if the enrollee or the enrollee's authorized representative signs the A.R.S. § 20-3113 Disclosure, they may have waived any rights to request arbitration of a qualifying surprise out-of-network bill.
6. "Balance bill" means all charges that exceed the enrollee's cost sharing requirements and the amount paid by the insurer.
7. "Date of service" means the latest date on which the health care provider rendered a related health care service that is the subject of a qualifying surprise out-of-network bill.
8. "Days" as used in this Article means calendar days unless specified as business days and does not include the day of the filing of a document.
9. "Department" means the Arizona Department of Insurance and Financial Institutions or an entity with which it contracts to administer the out-of-network claim dispute resolution process.
10. "Enrollee's authorized representative" means a person to whom an enrollee has given express written consent to represent the enrollee, the enrollee's parent or legal guardian, a person appointed by the court to act on behalf of the enrollee or the enrollee's legal representative. An enrollee's authorized representative shall not be someone who represents the provider's interests.
11. "Final resolution of a health care appeal" means that a member has a final decision under the review process provided by A.R.S. Title 20, Chapter 15, Article 2.
12. "Informal Settlement Teleconference" means a teleconference arranged by the Department that is held to settle the enrollee's qualifying surprise out-of-network bill prior to an Arbitration being scheduled. The parties to the Informal Settlement Teleconference are: (a) the enrollee or the enrollee's authorized representative; (b) the health insurer; and (c) the provider or the provider's representative.

13. "Qualifying surprise out-of-network bill" is a surprise out-of-network bill for health care services provided on or after January 1, 2019, that is disputed by the enrollee and:
    a. Is for health care services covered by the enrollee's health plan;
    b. Is for health care services provided in a network health care facility;
    c. Is for health care services performed by a provider who is not contracted to participate in the network that serves the enrollee's health plan;
    d. The enrollee has resolved any health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, that the enrollee may have had against the insurer following the health insurer's initial adjudication of the claim;
    e. The enrollee has not instituted a civil lawsuit or other legal action against the insurer or health care provider related to the surprise out-of-network bill or the health care services provided;
    f. The amount of the surprise out-of-network bill for which the enrollee is responsible for all related health care services provided by the health care provider whether contained in one or multiple bills, after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement, is at least $1,000.00; and
    g. One of the following applies:
        i. The bill is for emergency services, including under circumstances described by A.R.S. § 20-2803(A);
        ii. The bill is for health care services directly related to the emergency services that are provided during an inpatient admission to any network facility;
        iii. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated A.R.S. § 20-3113 Disclosure:
        iv. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated A.R.S. § 20-3113 Disclosure within a reasonable amount of time before the enrollee received the service;
        v. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated A.R.S. § 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative chose not to sign the Disclosure;
        vi. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated A.R.S. § 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative signed the Disclosure but the amount actually billed to the enrollee is greater than the estimated cost provided in the signed Disclosure.

NOTICES OF FINAL EXPEDITED RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Final Expedited Rulemakings. An agency prepares these notices under A.R.S. § 41-1013(9).

Expedited rulemaking is an accelerated rulemaking process that does not increase the cost of regulatory compliance, increase a fee, or reduce procedural rights of persons regulated. Other requirements to conduct expedited rulemaking are listed under A.R.S. § 41-1027.

Under the law an agency is required to file a Notice of Proposed Expedited Rulemaking for review. The notices in this section include *Register* publication dates where the Notices of Proposed Expedited Rulemaking were published.

The Office of the Secretary of State is the filing office and publisher of these rules.

Questions about the interpretation of expedited rules should be addressed to the agency promulgating the rules.

Refer to item 4 to contact the person charged with the rulemaking.

NOTICE OF FINAL EXPEDITED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES COMMUNICABLE DISEASES AND INFESTATIONS

[R23-231]

PREAMBLE

1. Article, Part, or Section Affected (as applicable) — **Rulemaking Action**

R9-6-1101	Amend
R9-6-1102	Amend
R9-6-1103	Amend
R9-6-1104	Amend

2. Citations to the agency's statutory authority for the rulemaking to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. §§ 36-132(A)(1), 36-136(A)(7), and 36-136(G)

Implementing statute: A.R.S. § 36-136(I)(1)

3. The effective date of the rules:

November 8, 2023 (*upon filing with the Office of the Secretary of State*)

4. Citations to all related notices published in the *Register* that pertain to the record of the final expedited rulemaking:

Notice of Rulemaking Docket Opening: 29 A.A.R. 1581, July 14, 2023

Notice of Proposed Expedited Rulemaking: 29 A.A.R. 1729, August 11, 2023

5. The agency's contact person who can answer questions about the rulemaking:

Name: Eugene Livar, Assistant Director

Address: Department of Health Services
Public Health Licensing Services
150 N. 18th Ave., Suite 500
Phoenix, AZ 85007-3248

Telephone: (602) 364-3846

Email: Eugene.Livar@azdhs.gov

or

Name: Stacie Gravito, Interim Office Chief

Address: Department of Health Services
Office of Administrative Counsel and Rules
150 N. 18th Ave., Suite 200
Phoenix, AZ 85007-3232

Telephone: (602) 542-1020

Fax: (602) 364-1150

Email: Stacie.Gravito@azdhs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, under A.R.S. § 41-1027, to include an explanation about the rulemaking:

Arizona Revised Statutes (A.R.S.) § 36-136(I)(1) requires the Arizona Department of Health Services (Department) to "define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases." A.R.S. § 13-1415 specifies requirements for court-ordered sexually transmitted disease (STD)-related testing. In accordance with A.R.S. § 41-1039(A), on June 13, 2023, the Governor's Office approved the Department's request to amend the STD-

related Testing and Notification rules to address issues identified in a five-year-review-report and make the rules more clear, concise, and understandable, including updating language from "sexually transmitted diseases" or "STD" to "sexually transmitted infections" or "STI." In many cases, the terms "STI" and "STD" are used interchangeably, however using the terms "sexually transmitted infections" or "STI" are usually the more scientifically accurate terms, since not everyone with an infection develops symptoms, and there is technically no disease without symptoms. STIs are infections that have not yet developed into diseases and can include bacteria, viruses, or parasites, such as pubic lice, usually transmitted during sexual activities through an exchange of bodily fluids or skin-to-skin contact where the infection is active. Nonsexual activities in which bodily fluids are exchanged can also transmit STIs. For example, people who share needles can infect each other with HIV. Sexually transmitted diseases, or STDs, on the other hand, result from STIs, suggesting a more serious problem. All STDs start as infections. Pathogens enter the body and begin multiplying. When these pathogens disrupt normal body functions or damage structures in the body, they become STDs. However, some STIs may never develop into diseases. According to the American Sexual Health Association, a growing number of public health experts believe the term STD can mislead people because "disease" suggests a person has an obvious medical problem, which is not always the case. The changes to be made during this rulemaking will not increase the cost of regulatory compliance, increase a fee, or reduce procedural rights of persons regulated, but reduce a burden due to outdated terminology without compromising health and safety. This rulemaking achieves the purpose prescribed in A.R.S. § 41-1027(A)(7) to implement a course of action proposed in a five-year-review report. The Department believes amending these rules will eliminate confusion and reduce regulatory burden.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review or rely on any study for this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state.

Not applicable

9. A summary of the economic, small business, and consumer impact:

Under A.R.S. § 41-1055(D)(2), the Department is not required to provide an economic, small business, and consumer impact statement.

10. A description of any changes between the proposed expedited rulemaking, including supplemental notices, and the final expedited rulemaking:

Between the proposed expedited rulemaking and the final expedited rulemaking, no changes were made to the rulemaking.

11. Agency's summary of the public or stakeholder comments or objections made about the rulemaking and the agency response to the comments:

No comments were received about this rulemaking.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rule does not require the issuance of a regulatory permit. Therefore, a general permit is not applicable.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

There are no federal rules applicable to the subject of the rule.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No such analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

14. Whether the rule was previously made, amended, or repealed as an emergency rules. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

The rule was not previously made as an emergency rule.

15. The full text of the rule follows:

TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES COMMUNICABLE DISEASES AND INFESTATIONS

ARTICLE 11. ~~STD-RELATED~~ STI-RELATED TESTING AND NOTIFICATION

Sections
R9-6-1101. Definitions
R9-6-1102. Health Care Provider Requirements
R9-6-1103. Local Health Agency Requirements
R9-6-1104. Court-ordered ~~STD-related~~ STI-related Testing

ARTICLE 11. ~~STD-RELATED~~ STI-RELATED TESTING AND NOTIFICATION

R9-6-1101. Definitions
In this Article, unless otherwise specified:

1. "Primary syphilis" means the initial stage of syphilis infection characterized by the appearance of one or more open sores in the genital area, anus, or mouth of an infected individual.
2. "Secondary syphilis" means the stage of syphilis infection occurring after primary syphilis and characterized by a rash that does not itch, fever, swollen lymph glands, and fatigue in an infected individual.
3. ~~"Sexually transmitted diseases" means the same as in A.R.S. § 13-1415.~~
4. ~~"STD" means a sexually transmitted disease or other disease that may be transmitted through sexual contact.~~
3. "Sexually transmitted infections" or "STI" means the same as "sexually transmitted diseases" in A.R.S. § 13-1415 or other diseases that may be transmitted through sexual contact.

R9-6-1102. Health Care Provider Requirements
When a laboratory report for a test ordered by a health care provider for a subject indicates that the subject is infected with an ~~STD~~ STI, the ordering health care provider or the ordering health care provider's designee shall:

1. Describe the test results to the subject;
2. Provide or arrange for the subject to receive the following information about the ~~STD~~ STI for which the subject was tested:
   a. A description of the ~~disease~~ infection or syndrome caused by the ~~STD~~ STI, including its symptoms;
   b. Treatment options for the ~~STD~~ STI and where treatment may be obtained;
   c. A description of how the ~~STD~~ STI is transmitted to others;
   d. A description of measures to reduce the likelihood of transmitting the ~~STD~~ STI to others and that it is necessary to continue the measures until the infection is eliminated;
   e. That it is necessary for the subject to notify individuals who may have been infected by the subject that the individuals need to be tested for the ~~STD~~ STI;
   f. The availability of assistance from local health agencies or other resources; and
   g. The confidential nature of the subject's test results;
3. Report the information required in R9-6-202 to a local health agency; and
4. If the subject is pregnant and is a syphilis case, inform the subject of the requirement that the subject obtain serologic testing for syphilis according to R9-6-381.

R9-6-1103. Local Health Agency Requirements
A. For each ~~STD~~ STI case, a local health agency shall:

1. Comply with the requirements in:
   a. R9-6-317(A)(1) and (2) for each chancroid case reported to the local health agency, and
   b. R9-6-381(A)(3)(a) through (c) for each syphilis case reported to the local health agency;
2. Offer or arrange for treatment for each ~~STD~~ STI case that seeks treatment from the local health agency for ~~symptoms of~~:
   a. Chancroid,
   b. Chlamydia infection,
   c. Gonorrhea, or
   d. Syphilis;
3. Provide information about the following to each ~~STD~~ STI case that seeks treatment from the local health agency:
   a. A description of the ~~disease~~ infection or syndrome caused by the applicable ~~STD~~ STI, including its symptoms;
   b. Treatment options for the applicable ~~STD~~ STI;
   c. A description of measures to reduce the likelihood of transmitting the ~~STD~~ STI to others and that it is necessary to continue the measures until the infection is eliminated; and
   d. The confidential nature of the ~~STD~~ STI case's test results; and
4. Inform the ~~STD~~ STI case that:
   a. A chlamydia or gonorrhea case must notify each individual, with whom the chlamydia or gonorrhea case has had sexual contact within 60 days preceding the onset of chlamydia or gonorrhea symptoms up to the date the chlamydia or gonorrhea case began treatment for chlamydia or gonorrhea infection, of the need for the individual to be tested for chlamydia or gonorrhea; and
   b. The Department or local health agency will notify, as specified in subsection (B), each contact named by a chancroid or syphilis case.

B. For each contact named by a chancroid or syphilis case, the Department or a local health agency shall:

1. Notify the contact named by a chancroid or syphilis case of the contact's exposure to chancroid or syphilis and of the need for the contact to be tested for:
   a. Chancroid, if the chancroid case has had sexual contact with the contact within 10 days preceding the onset of chancroid symptoms up to the date the chancroid case began treatment for chancroid infection; or
   b. Syphilis, if the syphilis case has had sexual contact with the contact within:
      i. 90 days preceding the onset of symptoms of primary syphilis up to the date the syphilis case began treatment for primary syphilis infection;
      ii. Six months preceding the onset of symptoms of secondary syphilis up to the date the syphilis case began treatment for secondary syphilis infection; or
      iii. 12 months preceding the date the syphilis case was diagnosed with syphilis if the syphilis case cannot identify when symptoms of primary or secondary syphilis began;
2. Offer or arrange for each contact named by a chancroid or syphilis case to receive testing and, if appropriate, treatment for chancroid or syphilis; and
3. Provide information to each contact named by a chancroid or syphilis case about:
   a. The characteristics of the applicable ~~STD~~ STI,
   b. The syndrome caused by the applicable ~~STD~~ STI,
   c. Measures to reduce the likelihood of transmitting the applicable ~~STD~~ STI, and
   d. The confidential nature of the contact's test results.

C. For each contact of a chlamydia or gonorrhea case who seeks treatment from a local health agency for ~~symptoms of~~ chlamydia or gonorrhea, the local health agency shall:
1. Offer or arrange for treatment for chlamydia or gonorrhea;
2. Provide information to each contact of a chlamydia or gonorrhea case about:
   a. The characteristics of the applicable ~~STD~~ STI,
   b. The syndrome caused by the applicable ~~STD~~ STI,
   c. Measures to reduce the likelihood of transmitting the applicable ~~STD~~ STI, and
   d. The confidential nature of the contact's test results.

R9-6-1104. Court-ordered ~~STD-related~~ STI-related Testing

A. A health care provider who receives the results of a test, ordered by the health care provider to detect an ~~STD~~ STI and performed as a result of a court order issued under A.R.S. § 13-1210, shall comply with the requirements in 9 A.A.C. 6, Article 8.

B. A health care provider who receives the results of a test, ordered by the health care provider to detect an ~~STD~~ STI and performed as a result of a court order issued under A.R.S. § 32-3207, shall comply with the requirements in 9 A.A.C. 6, Article 9.

C. When a court orders a test under A.R.S. § 13-1415 to detect a ~~sexually-transmitted disease~~ sexually transmitted infection, the prosecuting attorney who petitioned the court for the order shall provide to the Department:
1. A copy of the court order, including an identifying number associated with the court order;
2. The name and address of the victim; and
3. The name and telephone number of the prosecuting attorney or the prosecuting attorney's designee.

D. A person who tests a specimen of blood or another body fluid from a subject to detect a sexually-transmitted disease as authorized by a court order issued under A.R.S. § 13-1415 shall:
1. Be a certified laboratory, as defined in A.R.S. § 36-451;
2. Use a test approved by the U.S. Food and Drug Administration for use in ~~STD-related~~ STI-related testing; and
3. Report the test results for each subject to the submitting entity within five working days after obtaining the test results.

E. A submitting entity that receives the results of a test to detect a ~~sexually-transmitted disease~~ sexually transmitted infection that was performed as a result of a court order issued under A.R.S. § 13-1415 shall:
1. Notify the Department within five working days after receiving the results of the test to detect a ~~sexually-transmitted disease~~ sexually transmitted infection;
2. Provide to the Department:
   a. A written copy of the court order,
   b. A written copy of the results of the test to detect a ~~sexually-transmitted disease~~ sexually transmitted infection, and
   c. The name and telephone number of the submitting entity or submitting entity's designee; and
3. Either:
   a. Comply with the requirements in:
      i. R9-6-802(A)(2)(a) and (b), R9-6-802(D), and R9-6-802(F) through (J) for a subject who is not incarcerated or detained; and
      ii. R9-6-802(B), R9-6-802(D) through (G), and R9-6-802(J) for a subject who is incarcerated or detained; or
   b. Provide to the Department or the local health agency in whose designated service area the subject is living:
      i. The name and address of the subject;
      ii. A written copy of the results of the test to detect a ~~sexually-transmitted disease~~ sexually transmitted infection, if not provided as specified in subsection (E)(2)(b); and
      iii. Notice that the submitting entity did not provide notification as specified in subsection (E)(3)(a).

F. If the Department or a local health agency is notified by a submitting entity as specified in subsection (E)(3)(b), the Department or local health agency shall comply with the requirements in:
1. R9-6-802(A)(2)(a) and (b), R9-6-802(D), and R9-6-802(F) through (J) for a subject who is not incarcerated or detained; and
2. R9-6-802(B), R9-6-802(D) through (G), and R9-6-802(J) for a subject who is incarcerated or detained.

G. When the Department receives the results of a test to detect a ~~sexually-transmitted disease~~ sexually transmitted infection that was performed for a subject as a result of a court order issued under A.R.S. § 13-1415, the Department shall:
1. Provide to the victim:

a. A description of the results of the test to detect the ~~sexually transmitted disease~~ sexually transmitted infection,
b. The information specified in R9-6-802(D), and
c. A written copy of the test results for the ~~sexually transmitted disease~~ sexually transmitted infection; or

2. Provide to the local health agency in whose designated service area the victim is living:
a. The name and address of the victim,
b. A written copy of the results of the test to detect the ~~sexually transmitted disease~~ sexually transmitted infection, and
c. Notice that the Department did not provide notification as specified in subsection (G)(1).

H. If a local health agency is notified by the Department as specified in subsection (G)(2), the local health agency shall:

1. Provide to the victim:
a. A description of the results of the test to detect the ~~sexually transmitted disease~~ sexually transmitted infection;
b. The information specified in R9-6-802(D); and
c. A written copy of the test results for the ~~sexually transmitted disease~~ sexually transmitted infection; or

2. If the local health agency is unable to locate the victim, notify the Department that the local health agency did not inform the victim of the results of the test to detect the ~~sexually transmitted disease~~ sexually transmitted infection.

NOTICES OF RULEMAKING DOCKET OPENING

This section of the *Arizona Administrative Register* contains Notices of Rulemaking Docket Opening under A.R.S. § 41-1021.

A docket opening is the first part of the administrative rulemaking process. It is an "announcement" that an agency intends to work on its rules.

When an agency opens a rulemaking docket to consider rulemaking, the Administrative Procedure Act (APA) requires publication of the Notice of Rulemaking Docket Opening in the Register.

Under the APA, effective January 1, 1995, agencies must submit a Notice of Rulemaking Docket Opening before beginning the formal rulemaking process. An agency may file the Notice of Rulemaking Docket Opening along with the Notice of Proposed Rulemaking.

The Office of the Secretary of State is the filing office and publisher of these notices. Questions about the interpretation of this information should be directed to the agency contact person listed in item #4 of this notice.

NOTICE OF RULEMAKING DOCKET OPENING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

[R23-232]

1. Title and its heading: 4, Professions and Occupations
Chapter and its heading: 18, Naturopathic Physicians Medical Board
Article and its heading: 1, General Provisions
Section numbers: R4-18-101, R4-18-106, R4-18-108, R4-18-110, R4-18-111

2. The subject matter of the proposed rule:
Removal of rules displaying needless repetition. Insertion of language to provide clarity.

3. A citation to all published notices relating to the proceeding:
None at this time.

4. The name and address of agency personnel with whom persons may communicate regarding the rule:

Name:	Gail Anthony, Executive Director
Address:	Naturopathic Physicians Medical Board 1740 W. Adams, Suite 3002 Phoenix, AZ 85007
Telephone:	(602) 542-8242
Email:	Gail.anthony@nd.az.gov

5. The time during which the agency will accept written comments and the time and place where oral comments may be made:
The Board will continue to accept written comments at the location listed above until the close of record. The Board will schedule oral proceedings within the statutory mandated time-frame, which will be noticed by publication in the *Arizona Administrative Register*.

6. A timetable for agency decisions or other action on the proceeding, if known:
Unknown

NOTICE OF RULEMAKING DOCKET OPENING

TITLE 9. HEALTH SERVICES

CHAPTER 9. DEPARTMENT OF HEALTH SERVICES PROCUREMENT ORGANIZATIONS

[R23-233]

1. Title and its heading: 9, Health Services

Chapter and its heading: 9, Department of Health Services - Procurement Organizations

Article and its heading: 1, Procurement Organization Licensure

2, Administration for a Non-accredited Procurement Organization

3, Physical Plant; Transportation for a Non-accredited Procurement Organization

4, Administration for an Accredited Procurement Organization

Section numbers: R9-9-101 through R9-9-108, Table 1.1; R9-9-201 through R9-9-205; R9-9-301 through R9-9-305; R9-9-401 through R9-9-403 *(The Department may add, delete, or modify other Sections, as necessary.)*

2. The subject matter of the proposed rules:

Laws 2023, Ch. 194, amends Arizona Revised Statutes (A.R.S.) § 32-1307(A)(4), which transfers the authority, powers, duties, and responsibilities of the State Board of Funeral Directors and Embalmers for regulating funeral establishments, crematories, funeral directors, and embalmers to the Arizona Department of Health Services ("Department"). The Board of Funeral Directors and Embalmers had established rules to comply with statutory requirements in Arizona Administrative Code (A.A.C.) Title 4, Chapter 12. The Department had adopted rules for procurement organizations, pursuant to A.R.S. § 36-851.01, in A.A.C. Title 9, Chapter 9. After receiving rulemaking approval pursuant to A.R.S. § 41-1039(A), the Department plans to move and amend the rules currently in 4 A.A.C. 12 into 9 A.A.C. 9, consistent with the statutory changes made by Laws 2023, Ch. 194. In addition, the Department plans to incorporate requirements for transportation protection agreements that are related to preparing human remains or cremated remains, according to requirements added by Laws 2023, Ch. 95. As part of this rulemaking, existing requirements for procurement organizations in 9 A.A.C. 9 will be consolidated, clarified, and reorganized.

3. A citation to all published notices relating to the proceeding:

None

4. The name and address of agency personnel with whom persons may communicate regarding the rules:

Name: Megan McMinn, Bureau Chief
Address: Department of Health Services
Bureau of Special Licensing
150 N. 18th Ave., Suite 410
Phoenix, AZ 85007
Telephone: (602) 364-3052
Email: megan.mcminn@azdhs.gov

or

Name: Stacie Gravito, Office Chief
Address: Department of Health Services
Office of Administrative Counsel and Rules
150 N. 18th Ave., Suite 200
Phoenix, AZ 85007
Telephone: (602) 542-5879
Fax: (602) 364-1150
Email: stacie.gravito@azdhs.gov

5. The time during which the agency will accept written comments and the time and place where oral comments may be made:

To be announced in future notices regarding the rulemaking.

6. A timetable for agency decisions or other action on the proceeding, if known:

To be announced in future notices regarding the rulemaking.

NOTICES OF SUBSTANTIVE POLICY STATEMENT

SUMMARIES AND LOCATION OF STATEMENTS

Substantive policy statements are written expressions that inform the general public of an agency's current approach to rule or regulation practice as defined under A.R.S. § 41-1001(24).

Agencies are required to prepare a Notice of Substantive Policy Statement and publish the titles of its substantive policy statements, a summary of statements, and its website where full statements can be reviewed under A.R.S. § 41-1013(B)(9). These notices are published in this section of the *Register*.

Substantive policy statements are advisory only. A substantive policy statement does not include internal procedural documents that only affect an agency's internal procedures and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the APA.

Any person may petition an agency under A.R.S. § 41-1033(A)(2) to review an existing agency practice or substantive policy statement that the petitioner alleges to constitute a rule.

Contact the agency liaison listed under Item #6.

NOTICE OF SUBSTANTIVE POLICY STATEMENT

ARIZONA CORPORATION COMMISSON

[M23-53]

1. Title of the Substantive Policy Statement and the substantive policy statement number by which the substantive policy statement is referenced:

Arizona Corporation Commission Policy Statement Regarding Impacts of the Tax Cuts and Jobs Act; Decision No.76595.

2. Date the substantive policy statement was issued and the effective date of the policy statement if different from the issuance date:

The substantive policy statement was voted on and approved by the Commission at the February 6, 2018, Open Meeting. The Commission issued Decision No. 76595 for the substantive policy statement on February 26, 2018, and determined it was effective on that date.

3. Summary of the contents of the substantive policy statement:

This substantive policy statement addresses the anticipated need to account for impacts of the Tax Cuts and Jobs Act on ratemaking by ordering all utilities to take certain actions to address the TCJA impacts.

4. Federal or state constitutional provision; federal or state statute, administrative rule, or regulation; or final court judgment that underlies the substantive policy statement:

Article XV, Section 2 of the Arizona Constitution; Arizona Revised Statutes Title 40.

5. A statement as to whether the substantive policy statement is a new statement or a revision:

This is a new substantive policy statement.

6. The agency contact person who can answer questions about the substantive policy statement:

Name:	Nicole M. Layton, Staff Attorney
Address:	Arizona Corporation Commission Legal Division 1200 W. Washington St. Phoenix, AZ 85007
Telephone:	(602) 542-3402
Fax:	(602) 542-4870
Email:	NLayton@azcc.gov
Website:	www.azcc.gov

7. Information about where a person may obtain a copy of the substantive policy statement and the costs for obtaining the policy statement:

A copy of the substantive policy statement may be obtained at no cost from the Commission's website, https://docket.images.azcc.gov/0000186067.pdf?i=1697655013921.

NOTICE OF SUBSTANTIVE POLICY STATEMENT

ARIZONA CORPORATION COMMISSON

[M23-54]

1. Title of the Substantive Policy Statement and the substantive policy statement number by which the substantive policy statement is referenced:

Arizona Corporation Commission Amended Policy Statement Regarding Impacts of the Tax Cuts and Jobs Act; Decision No. 76619.

2. Date the substantive policy statement was issued and the effective date of the policy statement if different from the issuance date:

The substantive policy statement was voted on and approved by the Commission at the March 13, 2018, Open Meeting. The Commission issued Decision No. 76619 for the substantive policy statement on March 29, 2018, and determined it was effective on that date.

3. Summary of the contents of the substantive policy statement:

This substantive policy statement amends Decision No. 76595 to provide not-for-profit utilities additional time to meet Decision No. 76595 filing requirements.

4. Federal or state constitutional provision; federal or state statute, administrative rule, or regulation; or final court judgment that underlies the substantive policy statement:

Article XV, Section 2 of the Arizona Constitution; Arizona Revised Statutes Title 40

5. A statement as to whether the substantive policy statement is a new statement or a revision:

This is a revision to the Arizona Corporation Commission Policy Statement Regarding Impacts of the Tax Cuts and Jobs Act, Decision No. 76595.

6. The agency contact person who can answer questions about the substantive policy statement:

Name:	Nicole M. Layton, Staff Attorney
Address:	Arizona Corporation Commission Legal Division 1200 W. Washington St. Phoenix, AZ 85007
Telephone:	(602) 542-3402
Fax:	(602) 542-4870
Email:	NLayton@azcc.gov
Website:	www.azcc.gov

7. Information about where a person may obtain a copy of the substantive policy statement and the costs for obtaining the policy statement:

A copy of the substantive policy statement may be obtained at no cost from the Commission's website, https://docket.images.azcc.gov/0000186926.pdf?i=1697655013921.

NOTICE OF SUBSTANTIVE POLICY STATEMENT

ARIZONA CORPORATION COMMISSON

[M23-55]

1. Title of the Substantive Policy Statement and the substantive policy statement number by which the substantive policy statement is referenced:

Arizona Corporation Commission Policy Statement Regarding AG-Y Alternative Generation/Buy-Through Program; Decision No. 77043.

2. Date the substantive policy statement was issued and the effective date of the policy statement if different from the issuance date:

The substantive policy statement was voted on and approved by the Commission at the December 18, 2018, Open Meeting. The Commission issued Decision No. 77043 for the substantive policy statement on January 16, 2019, and determined it was effective on that date.

3. Summary of the contents of the substantive policy statement:

In this substantive policy statement, the Commission directs Arizona Public Service Company, Tucson Electric Power Company, and UNS Electric, Inc. to develop programs for wholesale power purchasing on behalf of medium and large commercial customers, pursuant to agreements reached between those customers and Generation Service Providers. The utilities are further directed to file program proposals within their next rate case for Commission approval.

4. Federal or state constitutional provision; federal or state statute, administrative rule, or regulation; or final court judgment that underlies the substantive policy statement:

Article XV, Section 2 of the Arizona Constitution; Arizona Revised Statutes Title 40.

5. A statement as to whether the substantive policy statement is a new statement or a revision:

This is a new substantive policy statement.

6. The agency contact person who can answer questions about the substantive policy statement:

Name: Nicole M. Layton, Staff Attorney
Address: Arizona Corporation Commission
Legal Division
1200 W. Washington St.
Phoenix, AZ 85007
Telephone: (602) 542-3402
Fax: (602) 542-4870
Email: NLayton@azcc.gov
Website: www.azcc.gov

7. Information about where a person may obtain a copy of the substantive policy statement and the costs for obtaining the policy statement:

A copy of the substantive policy statement may be obtained at no cost from the Commission's website, https://docket.images.azcc.gov/0000195196.pdf?i=1697644982577.

NOTICES OF AGENCY OMBUDSMAN

The Administrative Procedure Act requires the publication of Notices of Agency Ombudsman under A.R.S. §§ 41-1006(A) and 41-1013(B)(13).

An ombudsman is an agency's point of contact who assists members of the public or regulated community seeking information or guidance from the agency.

NOTICE OF AGENCY OMBUDSMAN

[M23-56]

1. The agency name: Department of Public Safety

2. The ombudsman's:

a. Name: Major Manuel Galvez

b. Title: Executive Officer - Ombudsman

c. Agency Division: Office of the Director

3. The ombudsman's office address to include the city, state and zip code:

Physical Address: 2102 W. Encanto Blvd.
Phoenix, AZ 85009

Mailing Address: POB 6638
Mail Drop 1000
Phoenix, AZ 85005-6638

4. The ombudsman's telephone number, fax number and email address, if available:

Telephone: (602) 223-5046

Email: mgalvezjr@azdps.gov

REGISTER INDEXES

The *Register* is published by volume in a calendar year (See "General Information" in the front of each issue for more information).

Abbreviations for rulemaking activity in this Index include:

PROPOSED RULEMAKING
PN = Proposed new Section
PM = Proposed amended Section
PR = Proposed repealed Section
P# = Proposed renumbered Section

SUPPLEMENTAL PROPOSED RULEMAKING
SPN = Supplemental proposed new Section
SPM = Supplemental proposed amended Section
SPR = Supplemental proposed repealed Section
SP# = Supplemental proposed renumbered Section

FINAL RULEMAKING
FN = Final new Section
FM = Final amended Section
FR = Final repealed Section
F# = Final renumbered Section

SUMMARY RULEMAKING
PROPOSED SUMMARY
PSMN = Proposed Summary new Section
PSMM = Proposed Summary amended Section
PSMR = Proposed Summary repealed Section
PSM# = Proposed Summary renumbered Section
FINAL SUMMARY
FSMN = Final Summary new Section
FSMM = Final Summary amended Section
FSMR = Final Summary repealed Section
FSM# = Final Summary renumbered Section

EXPEDITED RULEMAKING
PROPOSED EXPEDITED
PEN = Proposed Expedited new Section
PEM = Proposed Expedited amended Section
PER = Proposed Expedited repealed Section
PE# = Proposed Expedited renumbered Section
SUPPLEMENTAL EXPEDITED
SPEN = Supplemental Proposed Expedited new Section
SPEM = Supplemental Proposed Expedited amended Section
SPER = Supplemental Proposed Expedited repealed Section
SPE# = Supplemental Proposed Expedited renumbered Section
FINAL EXPEDITED
FEN = Final Expedited new Section
FEM = Final Expedited amended Section
FER = Final Expedited repealed Section
FE# = Final Expedited renumbered Section

EXEMPT RULEMAKING
EXEMPT
XN = Exempt new Section
XM = Exempt amended Section
XR = Exempt repealed Section
X# = Exempt renumbered Section
EXEMPT PROPOSED
PXN = Proposed Exempt new Section
PXM = Proposed Exempt amended Section
PXR = Proposed Exempt repealed Section
PX# = Proposed Exempt renumbered Section
EXEMPT SUPPLEMENTAL PROPOSED
SPXN = Supplemental Proposed Exempt new Section
SPXR = Supplemental Proposed Exempt repealed Section
SPXM = Supplemental Proposed Exempt amended Section
SPX# = Supplemental Proposed Exempt renumbered Section
FINAL EXEMPT RULEMAKING
FXN = Final Exempt new Section
FXM = Final Exempt amended Section
FXR = Final Exempt repealed Section
FX# = Final Exempt renumbered Section

EMERGENCY RULEMAKING
EN = Emergency new Section
EM = Emergency amended Section
ER = Emergency repealed Section
E# = Emergency renumbered Section
EEXP = Emergency expired

RECODIFICATION OF RULES
RC = Recodified

REJECTION OF RULES
RJ = Rejected by the Attorney General

TERMINATION OF RULES
TN = Terminated proposed new Sections
TM = Terminated proposed amended Section
TR = Terminated proposed repealed Section
T# = Terminated proposed renumbered Section

RULE EXPIRATIONS
EXP = Rules have expired
See also "emergency expired" under emergency rulemaking

CORRECTIONS
C = Corrections to Published Rules

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RULEMAKING ACTIVITY INDEX

Rulemakings are listed in the Index by Chapter, Section number, rulemaking activity abbreviation and volume page number. Use the page guide above to determine the *Register* issue number to review the rule. Headings for the Subchapters, Articles, Parts, and Sections are not indexed.

THIS INDEX INCLUDES RULEMAKING ACTIVITY THROUGH ISSUE 46 OF VOLUME 29.

Insurance and Financial Institutions, Department of - Insurance Division

Land Department, State

Livestock Loss Board, Arizona

Pharmacy, Board of

OTHER NOTICES AND PUBLIC RECORDS INDEX

Other legal notices required to be published under the Administrative Procedure Act, such as Rulemaking Docket Openings, are included in this Index by volume page number. Notices of Agency Ombudsman, Substantive Policy Statements, Proposed Delegation Agreements, and other applicable public records as required by law are also listed in this Index by volume page number.

THIS INDEX INCLUDES OTHER NOTICE ACTIVITY THROUGH ISSUE 46 OF VOLUME 29.

Formal Rulemaking Advisory Committee, Notices of

Governor's Office

Governor's Regulatory Review Council

Ombudsman, Notices of Agency

Public Information, Notices of

Substantive Policy Statement,

Notices of

RULES EFFECTIVE DATES CALENDAR

A.R.S. § 41-1032(A), as amended by Laws 2002, Ch. 334, § 8 (effective August 22, 2002), states that a rule generally becomes effective 60 days after the day it is filed with the Secretary of State's Office. The following table lists filing dates and effective dates for rules that follow this provision. Please also check the rulemaking Preamble for effective dates.

January		**February**		**March**		**April**		**May**		**June**	
Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date
1/1	3/2	2/1	4/2	3/1	4/30	4/1	5/31	5/1	6/30	6/1	7/31
1/2	3/3	2/2	4/3	3/2	5/1	4/2	6/1	5/2	7/1	6/2	8/1
1/3	3/4	2/3	4/4	3/3	5/2	4/3	6/2	5/3	7/2	6/3	8/2
1/4	3/5	2/4	4/5	3/4	5/3	4/4	6/3	5/4	7/3	6/4	8/3
1/5	3/6	2/5	4/6	3/5	5/4	4/5	6/4	5/5	7/4	6/5	8/4
1/6	3/7	2/6	4/7	3/6	5/5	4/6	6/5	5/6	7/5	6/6	8/5
1/7	3/8	2/7	4/8	3/7	5/6	4/7	6/6	5/7	7/6	6/7	8/6
1/8	3/9	2/8	4/9	3/8	5/7	4/8	6/7	5/8	7/7	6/8	8/7
1/9	3/10	2/9	4/10	3/9	5/8	4/9	6/8	5/9	7/8	6/9	8/8
1/10	3/11	2/10	4/11	3/10	5/9	4/10	6/9	5/10	7/9	6/10	8/9
1/11	3/12	2/11	4/12	3/11	5/10	4/11	6/10	5/11	7/10	6/11	8/10
1/12	3/13	2/12	4/13	3/12	5/11	4/12	6/11	5/12	7/11	6/12	8/11
1/13	3/14	2/13	4/14	3/13	5/12	4/13	6/12	5/13	7/12	6/13	8/12
1/14	3/15	2/14	4/15	3/14	5/13	4/14	6/13	5/14	7/13	6/14	8/13
1/15	3/16	2/15	4/16	3/15	5/14	4/15	6/14	5/15	7/14	6/15	8/14
1/16	3/17	2/16	4/17	3/16	5/15	4/16	6/15	5/16	7/15	6/16	8/15
1/17	3/18	2/17	4/18	3/17	5/16	4/17	6/16	5/17	7/16	6/17	8/16
1/18	3/19	2/18	4/19	3/18	5/17	4/18	6/17	5/18	7/17	6/18	8/17
1/19	3/20	2/19	4/20	3/19	5/18	4/19	6/18	5/19	7/18	6/19	8/18
1/20	3/21	2/20	4/21	3/20	5/19	4/20	6/19	5/20	7/19	6/20	8/19
1/21	3/22	2/21	4/22	3/21	5/20	4/21	6/20	5/21	7/20	6/21	8/20
1/22	3/23	2/22	4/23	3/22	5/21	4/22	6/21	5/22	7/21	6/22	8/21
1/23	3/24	2/23	4/24	3/23	5/22	4/23	6/22	5/23	7/22	6/23	8/22
1/24	3/25	2/24	4/25	3/24	5/23	4/24	6/23	5/24	7/23	6/24	8/23
1/25	3/26	2/25	4/26	3/25	5/24	4/25	6/24	5/25	7/24	6/25	8/24
1/26	3/27	2/26	4/27	3/26	5/25	4/26	6/25	5/26	7/25	6/26	8/25
1/27	3/28	2/27	4/28	3/27	5/26	4/27	6/26	5/27	7/26	6/27	8/26
1/28	3/29	2/28	4/29	3/28	5/27	4/28	6/27	5/28	7/27	6/28	8/27
1/29	3/30			3/29	5/28	4/29	6/28	5/29	7/28	6/29	8/28
1/30	3/31			3/30	5/29	4/30	6/29	5/30	7/29	6/30	8/29
1/31	4/1			3/31	5/30			5/31	7/30		

July		August		September		October		November		December	
Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date
7/1	8/30	8/1	9/30	9/1	10/31	10/1	11/30	11/1	12/31	12/1	1/30
7/2	8/31	8/2	10/1	9/2	11/1	10/2	12/1	11/2	1/1	12/2	1/31
7/3	9/1	8/3	10/2	9/3	11/2	10/3	12/2	11/3	1/2	12/3	2/1
7/4	9/2	8/4	10/3	9/4	11/3	10/4	12/3	11/4	1/3	12/4	2/2
7/5	9/3	8/5	10/4	9/5	11/4	10/5	12/4	11/5	1/4	12/5	2/3
7/6	9/4	8/6	10/5	9/6	11/5	10/6	12/5	11/6	1/5	12/6	2/4
7/7	9/5	8/7	10/6	9/7	11/6	10/7	12/6	11/7	1/6	12/7	2/5
7/8	9/6	8/8	10/7	9/8	11/7	10/8	12/7	11/8	1/7	12/8	2/6
7/9	9/7	8/9	10/8	9/9	11/8	10/9	12/8	11/9	1/8	12/9	2/7
7/10	9/8	8/10	10/9	9/10	11/9	10/10	12/9	11/10	1/9	12/10	2/8
7/11	9/9	8/11	10/10	9/11	11/10	10/11	12/10	11/11	1/10	12/11	2/9
7/12	9/10	8/12	10/11	9/12	11/11	10/12	12/11	11/12	1/11	12/12	2/10
7/13	9/11	8/13	10/12	9/13	11/12	10/13	12/12	11/13	1/12	12/13	2/11
7/14	9/12	8/14	10/13	9/14	11/13	10/14	12/13	11/14	1/13	12/14	2/12
7/15	9/13	8/15	10/14	9/15	11/14	10/15	12/14	11/15	1/14	12/15	2/13
7/16	9/14	8/16	10/15	9/16	11/15	10/16	12/15	11/16	1/15	12/16	2/14
7/17	9/15	8/17	10/16	9/17	11/16	10/17	12/16	11/17	1/16	12/17	2/15
7/18	9/16	8/18	10/17	9/18	11/17	10/18	12/17	11/18	1/17	12/18	2/16
7/19	9/17	8/19	10/18	9/19	11/18	10/19	12/18	11/19	1/18	12/19	2/17
7/20	9/18	8/20	10/19	9/20	11/19	10/20	12/19	11/20	1/19	12/20	2/18
7/21	9/19	8/21	10/20	9/21	11/20	10/21	12/20	11/21	1/20	12/21	2/19
7/22	9/20	8/22	10/21	9/22	11/21	10/22	12/21	11/22	1/21	12/22	2/20
7/23	9/21	8/23	10/22	9/23	11/22	10/23	12/22	11/23	1/22	12/23	2/21
7/24	9/22	8/24	10/23	9/24	11/23	10/24	12/23	11/24	1/23	12/24	2/22
7/25	9/23	8/25	10/24	9/25	11/24	10/25	12/24	11/25	1/24	12/25	2/23
7/26	9/24	8/26	10/25	9/26	11/25	10/26	12/25	11/26	1/25	12/26	2/24
7/27	9/25	8/27	10/26	9/27	11/26	10/27	12/26	11/27	1/26	12/27	2/25
7/28	9/26	8/28	10/27	9/28	11/27	10/28	12/27	11/28	1/27	12/28	2/26
7/29	9/27	8/29	10/28	9/29	11/28	10/29	12/28	11/29	1/28	12/29	2/27
7/30	9/28	8/30	10/29	9/30	11/29	10/30	12/29	11/30	1/29	12/30	2/28
7/31	9/29	8/31	10/30			10/31	12/30			12/31	3/1

REGISTER PUBLISHING DEADLINES

The Secretary of State's Office publishes the Register weekly. There is a three-week turnaround period between a deadline date and the publication date of the Register. The weekly deadline dates and issue dates are shown below. Council meetings and Register deadlines do not correlate. Also listed are the earliest dates on which an oral proceeding can be held on proposed rulemakings or proposed delegation agreements following publication of the notice in the Register.

Deadline Date Friday, 5:00 p.m. *(*earlier date due to holiday)*	***Register* Publication Date**	**Oral Proceeding may be scheduled on or after**
June 16, 2023	July 7, 2023	August 7, 2023
June 23, 2023	July 14, 2023	August 14, 2023
June 30, 2023	July 21, 2023	August 21, 2023
July 7, 2023	July 28, 2023	August 28, 2023
July 14, 2023	August 4, 2023	September 5, 2023
July 21, 2023	August 11, 2023	September 11, 2023
July 28, 2023	August 18, 2023	September 18, 2023
August 4, 2023	August 25, 2023	September 25, 2023
August 11, 2023	September 1, 2023	October 2, 2023
August 18, 2023	September 8, 2023	October 10, 2023
August 25, 2023	September 15, 2023	October 16, 2023
September 1, 2023	September 22, 2023	October 23, 2023
September 8, 2023	September 29, 2023	October 30, 2023
September 15, 2023	October 6, 2023	November 6, 2023
September 22, 2023	October 13, 2023	November 13, 2023
September 29, 2023	October 20, 2023	November 20, 2023
October 6, 2023	October 27, 2023	November 27, 2023
October 13, 2023	November 3, 2023	December 4, 2023
October 20, 2023	November 10, 2023	December 11, 2023
October 27, 2023	November 17, 2023	December 18, 2023
November 3, 2023	November 24, 2023	December 26, 2023
*November 9, 2023	December 1, 2023	January 2, 2024
November 17, 2023	December 8, 2023	January 8, 2024
November 24, 2023	December 15, 2023	January 16, 2024
December 1, 2023	December 22, 2023	January 22, 2024
December 8, 2023	December 29, 2023	January 29, 2024
December 15, 2023	January 5, 2024	February 5, 2024
December 22, 2023	January 12, 2024	February 12, 2024
December 29, 2023	January 19, 2024	February 20, 2024

GOVERNOR'S REGULATORY REVIEW COUNCIL DEADLINES

The following deadlines apply to all Five-Year Review Reports and any adopted rule submitted to the Governor's Regulatory Review Council. Council meetings and *Register* deadlines do not correlate. We publish these deadlines under A.R.S. § 41-1013(B)(15).

All rules and Five-Year Review Reports are due in the Council office by 5 p.m. of the deadline date. The Council's office is located at 100 N. 15th Ave., Suite 305, Phoenix, AZ 85007. For more information, call (602) 542-2058 or visit https://grrc.az.gov.

GOVERNOR'S REGULATORY REVIEW COUNCIL DEADLINES FOR 2023/2024

(MEETING DATES ARE SUBJECT TO CHANGE)

[M22-60/M23-49]

* Materials must be submitted by **5 PM** on dates listed as a deadline for placement on a particular agenda. Placement on a particular agenda is not guaranteed.

DEADLINE FOR PLACEMENT ON AGENDA*	FINAL MATERIALS SUBMITTED TO COUNCIL	DATE OF COUNCIL STUDY SESSION	DATE OF COUNCIL MEETING
Tuesday October 24, 2023	*Tuesday* November 21, 2023	*Tuesday* November 28, 2023	*Tuesday* December 5, 2023
Tuesday November 21, 2023	*Tuesday* December 19, 2023	***Wednesday*** December 27, 2023	*Tuesday* January 2, 2024
Tuesday December 19, 2023	*Tuesday* January 23, 2024	*Tuesday* January 30, 2024	*Tuesday* February 6, 2024
Tuesday January 23, 2024	*Tuesday* February 20, 2024	*Tuesday* February 27, 2024	*Tuesday* March 5, 2024
Tuesday February 20, 2024	*Tuesday* March 19, 2024	*Tuesday* March 26, 2024	*Tuesday* April 2, 2024
Tuesday March 19, 2024	*Tuesday* April 23, 2024	*Tuesday* April 30, 2024	*Tuesday* May 7, 2024
Tuesday April 23, 2024	*Tuesday* May 21, 2024	***Wednesday*** May 29, 2024	*Tuesday* June 4, 2024
Tuesday May 21, 2024	*Tuesday* June 18, 2024	*Tuesday* June 25, 2024	*Tuesday* July 2, 2024
Tuesday June 18, 2024	*Tuesday* July 23, 2024	*Tuesday* July 30, 2024	*Tuesday* August 6, 2024
Tuesday July 23, 2024	*Tuesday* August 20, 2024	*Tuesday* August 27, 2024	***Wednesday*** September 4, 2024
Tuesday August 20, 2024	*Tuesday* September 17, 2024	*Tuesday* September 24, 2024	*Tuesday* October 1, 2024
Tuesday September 17, 2024	*Tuesday* October 22, 2024	*Tuesday* October 29, 2024	*Tuesday* November 5, 2024
Tuesday October 22, 2024	*Tuesday* November 19, 2024	*Tuesday* November 26, 2024	*Tuesday* December 3, 2024
Tuesday November 19, 2024	*Tuesday* December 24, 2024	*Tuesday* December 31, 2024	*Tuesday* January 7, 2025
Tuesday December 24, 2024	*Tuesday* January 21, 2025	*Tuesday* January 28, 2025	*Tuesday* February 4, 2025

GOVERNOR'S REGULATORY REVIEW COUNCIL

NOTICE OF ACTION TAKEN AT THE OCTOBER 31, 2023 MEETING

[M23-57]

A. ARIZONA STATE LAND DEPARTMENT PROGRESS UPDATE ON ARTICLES REVIEWED OUTSIDE OF THE FIVE-YEAR REVIEW PROCESS PURSUANT TO A.R.S. § 41-1056(D) AND A.R.S. § 41-1056(F) EXTENSION REQUEST TO AMEND OR REPEAL RULES IN TITLE 12, CHAPTER 5, ARTICLES 7-9 AND 11 PURSUANT TO A.R.S. § 41-1056(E)

COUNCIL ACTION:

- **Granted A.R.S. § 41-1056(F) extension request to submit rulemaking to amend or repeal rules in Title 12, Chapter 5, Articles 7-9 and 11 pursuant to A.R.S. § 41-1056(E) by April 30, 2024;**
- **Granted extension to submit A.R.S. § 41-1056(D) rule review for Title 12, Chapter 5, Articles 12 and 17-25 by April 30, 2024;**
- **Voted to require the State Land Department to provide the Council with bi-monthly progress updates regarding the rulemaking to amend or repeal rules in Title 12, Chapter 5, Articles 7-9 and 11 and the Title 12, Chapter 5, Article 12 and 17-25 rule review.**